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VOLUME II

# MEDICAID MANAGEMENT INFORMATION SYSTEM

## GENERAL SYSTEMS DESIGN FOR TITLE XIX

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service

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THE CLAIMS PROCESSING SUBSYSTEM OF THE MODEL MEDICAID MANAGEMENT INFORMATION SYSTEM IS AN INTEGRATED SET OF COMPUTERIZED AND MANUAL PROCESSING STEPS WHICH PERFORM ALL THE FUNCTIONS NECESSARY TO RECEIVE, APPROVE OR DISALLOW, AND RENDER PAYMENT FOR CLAIMS. THE SUBSYSTEM IS DIVIDED INTO FIVE MODULES. FOUR OF THE MODULES ARE DESIGNED TO INTERACT DAILY AND GENERATE A COMPUTER FILE OF ALLOWED AND DISALLOWED CLAIMS. PERIODICALLY ON A CYCLE ESTABLISHED BY INDIVIDUAL STATE POLICY, THE FIFTH MODULE COLLECTS THE COMPUTER FILES AND PRODUCES PAYMENT INSTRUMENTS. THE CLAIMS PROCESSING SUBSYSTEM INTERFACES TO A VARYING DEGREE WITH ALL OF THE OTHER SUBSYSTEMS COMPRISING THE MODEL SYSTEM.

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# MEDICAID
# MANAGEMENT INFORMATION SYSTEM

## GENERAL SYSTEMS DESIGN
## FOR TITLE XIX

VOLUME II: Claims Processing Subsystem and Reference File Subsystem

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social And Rehabilitation Service
Associate Administrator For Information Systems

Division of Medicaid Systems

SRS-75-06002

MEDICAID
MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

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# INTRODUCTION

## A. GENERAL

The General Systems Design of the Model Medicaid Management Information System is a product of the Division of Management Information and Payment Systems, Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

The General Systems Design is comprised of an introduction, a management overview or executive brief, six sections describing individual subsystems within the Model System, and an Appendix. This material has been grouped for convenience of handling into five volumes.

## B. DOCUMENTATION ORGANIZATION

The General Systems Design documentation for each of the six subsystems that make up the Model System is presented within its respective section as follows:

1. Subsystem summary, where the subsystem objectives are itemized and a general description of the subsystem is provided.

2. Design elements, where all assumptions and constraints imposed are listed, where considerations affecting the design of the subsystem are discussed, and where the controls and audit trails established to insure subsystem integrity are listed.

3. Processing flow, where a detail description is furnished of how each module functions within the subsystem.

4. Subsystem outputs, where each major output is defined as to purpose, distribution, content, and format.

5. Subsystem inputs, where each major input is defined as to use, source, and data element content.

6. Subsystem files, where each major file is defined as to function and data element content.

7. Input/Output matrix, where data elements used in a subsystem are identified as to their source and distribution.

Volume V - Appendix contains the following General Systems Design documentation:

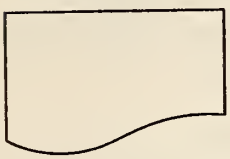
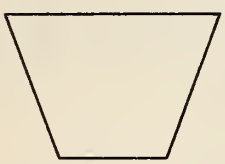
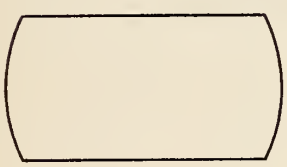
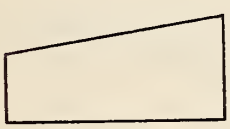
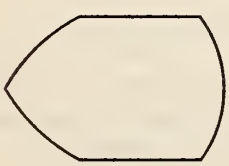
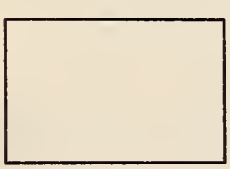
1. A glossary which indicates the specialized meaning of various terms used in the design documentation.

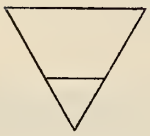
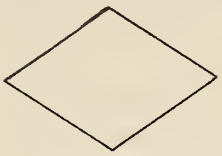
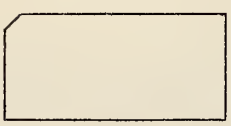
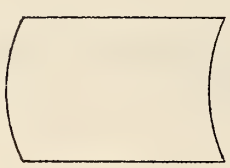
2. Data element definitions which provide an explanation of each data element, and where applicable, a recommended code structure.

C. FLOWCHART SYMBOL EXPLANATION

In certain portions of the General Systems Design documentation flowcharts are used to graphically describe the processing flow. An explanation of the symbols employed is furnished on the following pages.

# FLOWCHART SYMBOLS

| SYMBOL | EXPLANATION |
| --- | --- |
| | Terminal point - indicates exit from a module to another module or subsystem; indicates entry to a module from another module or subsystem. |
|  | Document - computer printed output; manually created reports; source documents. |
|  | Manual process step - a step in which no equipment, other than normal clerical devices, is used. |
|  | Keying - a process step involving the generation of machine-readable records using a key-driven device. |
|  | Manual input - information input by on-line keyboards. |
|  | Display - information display by on-line video devices. |
|  | Computer processing step - processing which takes place in the computer. |

| SYMBOL | EXPLANATION |
| --- | --- |
|  | Off-line file - a file of non-machine-readable data such as documents. |
|  | Decision - a processing step (manual or computer) in which a decision is made and one of several alternatives selected. |
| | Off-line equipment processing - a processing step which utilizes off-line equipment (e.g., sorter, microfilm machine). |
|  | Input/Output function in card medium. |
|  | On-line file - a file composed of machine-readable data (e.g., drum, tape, disk). |
| | On-page connector - indicates entry to a process from a point on the same page; indicates exit to a process on the same page. |
| | Off-page connector - indicates entry to a process from another page; indicates exit to a point on another page. |

## D. DOCUMENTATION NOMENCLATURE

### 1. Design Element Identification

As a part of the General Design documentation for individual subsystems, specifications for inputs, outputs, and data files are provided. To provide a means of unique identification for these design elements, the following reference scheme is used:

XX-Y-ZZ

where XX identifies the source subsystem for the design element per the following abbreviations:

- RS Recipient Subsystem
- PS Provider Subsystem
- CP Claims Processing Subsystem
- RF Reference File Subsystem
- SU Surveillance and Utilization Review Subsystem
- MR Management and Administrative Reporting Subsystem

where Y identifies the design element per the following code:

- O Output
- I Input
- F File

where ZZ is a unique two digit number identifying the particular design element.

### 2. Data Element Numbering

Each subsystem serves as a point of entry for various data elements that are collected, processed, and displayed on one or more outputs from the Model System. The following ranges of numbers are allocated by subsystem for assignment to data elements that originate in that subsystem.

- 100-199 Recipient Subsystem
- 200-299 Provider Subsystem
- 300-499 Claims Processing Subsystem

500-599 Reference File Subsystem

600-699 Management and Administrative Reporting Subsystem

700-799 Surveillance and Utilization Review Subsystem

3. Flowchart Connectors

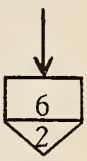
As a part of the documentation of each subsystem, module flowcharts are furnished to describe the processing flow. In some instances, more than one flowchart page is required for a module. This situation results in the need for processing connectors as follows:

where X is the number of a specific flowchart page. If the flowchart indicates an exit connector, then X is the page to which exit is made. If the flowchart indicates an entry connector, then X is the page upon which entry is made.

Y is the unique number designating a particular exit or entry on the page.

For example:

From Page 4 exit connector




To Page 6 entry connector

# MEDICAID

# MANAGEMENT INFORMATION SYSTEM

## SECTION IV

## CLAIMS PROCESSING SUBSYSTEM

SECTION IV

CLAIMS PROCESSING SUBSYSTEM

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# IV. CLAIMS PROCESSING SUBSYSTEM

## A. SUBSYSTEM SUMMARY

### 1. Objectives

The Claims Processing Subsystem has been developed to accomplish the following primary objectives:

a. Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.

b. Establish control over all transactions during their entire processing cycle.

c. Verify that all providers submitting input are properly enrolled.

d. Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.

e. Ensure that all input submitted to the subsystem is processed completely.

f. Verify that charges submitted by providers are reasonable and within acceptable limits.

g. Ensure that reimbursements to providers are rendered promptly and correctly.

h. Maintain accurate and complete registers and audit trails of all processing.

i. Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.

j. Respond to queries concerning recipient eligibility and benefit status.

k. Process approved prior authorization requests.

l. Process provider credits and adjustments.

### 2. General Description

The Claims Processing Subsystem is an integrated set of computerized and manual processing steps which

perform all the functions necessary to receive, approve or disallow, and render payment for claims.

The subsystem is divided into five modules. Four of the modules are designed to interact daily and generate a computer file of allowed and disallowed claims. Periodically, on a cycle established by individual State policy, the fifth module collects the computer files and produces payment instruments.

The five modules are:

a. Input preparation.

b. Disposition.

c. Adjudication.

d. Distribution.

e. Payment.

The Claims Processing Subsystem interfaces to a varying degree with all of the other subsystem comprising the Model System. The major interface areas are:

a. Recipient Subsystem -- The Medicaid Eligibility Master File maintained by this subsystem is used by Claims Processing to verify the eligiblity of recipients.

b. Provider Subsystem -- The Provider Master File is accessed to ensure that providers are eligible and to obtain provider name and addresses for the preparation and mailing of payment instruments.

c. Surveillance and Utilization Review Subsystem -- A file of allowed and disallowed claims generated by Claims Processing is periodically used as the major input to this subsystem.

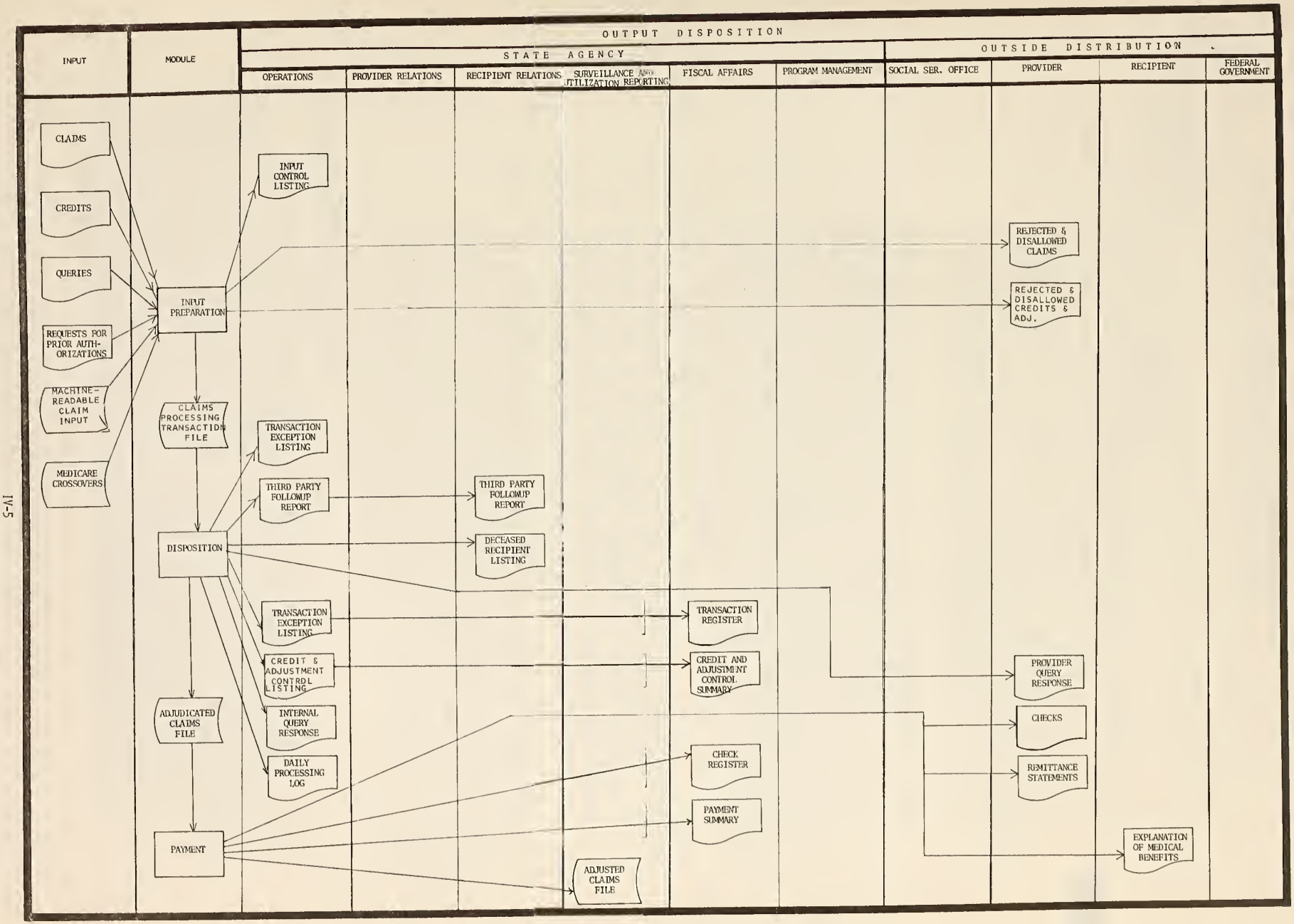
d. Management and Administrative Reporting Subsystem -- Several claims processing files are accessed periodically by this subsystem to obtain certain report data for presentation to management.

3. Information Flow Diagram

The Claims Processing Subsystem Information Flow Diagram found on the following page provides an overview

of the Claims Processing Subsystem. The diagram shows the interrelationships of the processing modules and identifies the principal user of each module output. A description of the processing steps and flows of information within the subsystem is presented in detail in Section IV-C.

# CLAIMS PROCESSING INFORMATION FLOW DIAGRAM



## B. DESIGN ELEMENTS

### 1. Constraints and Assumptions

The Claims Processing Subsystem was designed based on the following constraints and assumptions:

a. Provider and recipient data contained in the appropriate master files is accurate and timely. The Claims Processing Subsystem assumes that the Provider and Recipient Subsystems, or their equivalents, create and maintain these files.

b. The design was done under the assumption that providers must submit claims by means of a standard approved claim form, compatible with this system's input requirements, and not on their own billing forms. A similar assumption was made regarding those providers submitting machine-readable claims. These providers are assumed to furnish all data that would normally be submitted on claim forms and that the data is in an approved format.

c. The minimum Model System computer configuration serves as a principal design constraint. It should be recognized, however, that larger configurations will result in enhanced operational efficiencies and processing times.

d. It is assumed that the Model System Management and Administrative Reporting Subsystem interfaces with the Claims Processing Subsytem. As a result of this assumption, the Claims Processing Subsystem does not produce any management reports; but rather confines itself to accumulating data for management reporting.

### 2. Design Considerations

During the development of the general design of the Claims Processing Subsystem, a number of design decisions were required in areas where more than one approach was feasible. An evaluation was conducted on the advantages and drawbacks connected with each alternative identified, prior to adoption of a particular solution or approach for the Model System. The discussions that follow summarize, for each major item of consideration, the alternatives explored and the resulting Model System recommendation.

a. Data Entry Method

There are many means of entering claim data into a computer system. During the design of the Model System, four methods, which were assumed to be the most common, were evaluated. They are:

(1) Traditional keying methods.

(2) On-Line entry through some type of communications terminal.

(3) Optical character recognition (OCR) methods.

(4) Direct submission of machine-readable data by providers.

Keying methods have several advantages. Among these are: the ease of obtaining trained data entry personnel, the normal availability of backup facilities in case of unusual peak loads, the known reliability of the keying devices now available, and the obviation of sophisticated software personnel. Disadvantages of keying include: the inherent slowness of a data entry system which is interposed between the manual review and the computer processing of claims and the existence of another step at which errors can be introduced into the system. Because of the universal utility of keying and the general availability of the required equipment it must be considered the most popular choice for data entry.

There is a growing trend in State government toward large, centralized data processing installations. If such an installation is available to the Medicaid Agency, serious consideration should be given to on-line data entry. On-line data entry has several advantages including the ability to edit data in a conversational mode and the elimination of some lengthy input conversion steps. This method is especially suitable for claims with relatively low volume and complex edits (e.g., inpatient hospital claims).

OCR equipment has the advantage of moving data directly from source documents to the computer with little or no human intervention. Equipment with a high degree of flexibility is

quite expensive, which can be a significant disadvantage. However, if a State has sufficient volume or OCR equipment is available on a shared basis, this data entry method should be considered feasible, particularly for claims with high volume and simple data content, such as pharmacy claims.

The acceptance of direct input from providers was also considered to be acceptable as an alternative input method. This method, already in use in some locations, eliminates almost all input processing steps. Its inclusion in the Model System must be qualified by the assumption that the data submitted must be complete in all respects and in the proper format.

b. Medicare Crossover

The payment of Medicare deductibles and coinsurance by Medicaid presents the problem of timely and accurate exchanges of information between the Medicaid Claims Processing Agency and the Medicare intermediaries and carriers. Five methods of exchanging this information were evaluated. They are:

(1) Have the Medicare carriers and intermediaries pay all claims completely and bill the Medicaid Agency for the deductible and coinsurance amounts.

(2) The Medicaid Agency could receive Medicare claims, pay their total amount and bill the Medicare carriers and intermediaries for the amount covered by Title XVIII.

(3) The provider could wait until Medicare has paid its portion and then bill Medicaid for the deductibles and coinsurance.

(4) The Medicare claim document could be passed, after payment of Medicare liabilities, from the Medicare carrier or intermediary to the Medicaid Claims Processing Agency.

(5) A computerized file could be generated by the Medicare carriers and intermediaries. The file would contain

deductibles and coinsurance amounts payable by Medicaid and would serve as direct input to the Claims Processing Subsystem.

Method 1 was eliminated from consideration because of the problems involved in allowing Medicare agencies to disburse Medicaid funds. Method 2 would force the Medicaid Agency to disburse Medicare funds.

Method 3 has the disadvantage of forcing the provider to file two claims. The Medicaid Claims Processing Agency would not be aware of claims filed with Medicare, which presents possibilities of fraud. For this reason, Method 3 was eliminated.

Method 5 requires that Medicare Agencies make certain changes in their systems. The reasonable cost of such changes would, of course, be paid for by Medicaid. The expense is justifiable because this method promises ease and accuracy in accepting crossover claims into the Model System. Therefore, it is the recommended approach.

Method 4 is not as effective as Method 5, however, it is the approach recommended in those instances where Method 5 proves to be unfeasible.

c. Approval of Institutional Stay by Diagnosis

The approval of the length of institutional stays based on the diagnosis being treated has been tried in several health insurance programs, both public and private. When the approval procedure has been used properly and has had a sound information base, it has generally resulted in a reduction in the average length of inpatient stays. For this reason, the implementation of this technique should be considered.

Depending on the State policy, the approved length of stay can be a program limitation on payment or simply a guideline to detect improper utilization. The comparison of actual length of stay to a standard length of stay for a given diagnosis may be a part of the post payment or prepayment utilization review process or may be part of the

claim payment process depending on individual State policy. In any case, flexibility must be built into the system to allow for exceptional cases involving multiple diagnoses and cases where the discharge diagnosis differs from the admitting diagnosis.

Because of these variations in Medicaid policy in the different States, the method of implementing an institutional stay approval process is highly dependent upon the inpatient payment policy of the State. As a result, the approval of inpatient stay based on diagnosis is best addressed during the detail design phase of systems development rather than in the general design.

d. EPSDT Tracking

Federal regulations imply the concept of EPSDT "tracking", i.e., the association of diagnostic and treatment procedures to the results of screening.

There are two major methods for performing tracking. They are:

(1) The assumption method where diagnosis and treatment indicated on claims which enter the processing system within a certain number of days after screening are considered to be related to the results of screening.

(2) The direct method which calls for all services rendered as a result of a screening referral to be positively identified as such on the claim form.

In either method a Screening Related Treatment Code should be entered into the claims record once the relationship is determined so that the claim can be identified by the system for use in accumulating data about the EPSDT program.

The assumption method is least desirable in terms of providing direct knowledge of the relativity of a claim to the screening. The claims matching procedures necessary to implement this method, especially with claim filing time lags, is another major drawback to the assumption method.

The direct method is more acceptable because it does provide a direct linkage between screening and followup services and does not require the extensive matching process of the assumption method. The major drawback to this method is the introduction of new referral forms. However, the use of the referral form as a claim form may lessen this objection.

Probably the most desirable approach of all would be to use the assumption method in conjunction with the direct method. The advantage of this combined method would occur when under the direct method a provider fails to properly indicate on his claim form that his services were a result of a screening referral. In this situation use of the assumption method as a backup would still permit the identification of the service rendered as being screening related.

Claims for screening services can be stored in the Claims History File identified by the category of service code. A search of the Recipient Eligibility File will identify all recipients eligible for screening. All claims for these recipients can then be located in the Claims History File. This technique will allow the production of reports containing only EPSDT recipients. In the S/UR Subsystem the establishment of a class of recipients as "those receiving EPSDT services" to be used in the comparisons and exception processing of S/UR Subsystem could enhance the value of various reports.

3. Controls and Audit Trails

In order to ensure that all information is processed completely and accurately the following controls and audit trails have been established:

Manual Processing

a. Batch Control Log -- A manually maintained log of the progress of all transaction batches through the system.

b. Microfilm of all Input -- All transactions are microfilmed by batch.

Computer Processing

a. Transaction Register -- A detail list of all transactions processed through the system.

b. Credit and Adjustment Listing -- A supplement to the transaction register giving additional details concerning credits and adjustments.

c. Daily Process Log -- A daily report summarizing the transactions processed through the EDP processing.

d. Check Register -- A detail list of all checks written.

4. Data Elements Required for Institutional Review

Recent amendments to the Social Security Act (P.L. 92-603 and P.L. 93-233), and PSRO policy effective March 1, 1975, require that additional data elements related to institutional services be available through the MMIS. The new data elements are:

397 Operating Physician Number

398 Nature of Admission

399 Certification Status

400 Certification/Recertification Date

401 Certification Review Indicator

402 Days Certified Initially

403 Total Days Certified

404 Number of Requests for Extension

These data elements have been added to the Provider Claim input and the Claims Processing Transaction File, the Claims Processing Suspense File, and the Adjudicated Claims File. The State Medicaid Plan should describe the nature and flow of data to organizations that perform medical care review and utilization review. The Medicaid State Agency controls administration and payment of claims for Medicaid services to qualify for payment of FFP matching money.

Regulations of Social and Rehabilitation Services for utilization control of institutional care and services (CFR 250.18) require the following data elements in addition to others listed. They are:

252 Type of Facility Review System
253 Name of Facility Administrator
405 Review Type
406 Review Date
407 Review Outcome
408 State Medical Assistance Unit Review Action
409 Plan of Care Development Date
410 Treatment Orders Code
411 Medications Orders Code
412 Restorative and Rehabilitative Services Orders Code
413 Diet Orders Code
414 Social Services Orders Code
415 Continuing Care Plan and Discharge Plan Code
416 Activities Orders Code

These data elements are useful for reporting various reviews and plans of care required for each patient. Their use in the MMIS is not yet specified, but will be incorporated in ensuing general systems design revisions including subsystem outputs, inputs, file structures, and design elements.

The following list of minimum reporting requirements for utilization control is recommended. Some reports are currently specified in the MARS and S/UR subsystems reports; the others will be specified in later MMIS additions. These reports will be required for each facility and in Statewide summary form, by level of care (Hospital, IMD, SNF, ICF).

1. Admission Certification Analysis (including)
   Periodic Recertification (and sixty-day recertification)

2. Plan of Care Filing Analysis

3. Review Tracking Analysis (including the following report items)

   -number of XIX admissions
   -number of XIX discharges
   -number of XIX patient days
   -number of facility XIX utilization reviews
   -number of XIX discharges due to UR's
   -number of XIX recipients approved for stay extension
   -number of XIX recipients recommended for unavailable alternative care
   -number of XIX recipients transferred to other facilities
   -number of XIX recipients discharged to home care
   (Statewide report items)
   -number of XIX eligibles on the welfare roles
   -number of XIX eligibles on the Medicaid roles
   -number of facilities reporting on Review Tracking Analysis
   -number of on-site Medical Reviews and Independent Professional Reviews

4. Post Payment and Discharge Utilization Review (Summary and Detail Reports of Provider and Recipient Profiles). These include Norms, Standards, and Exceptions.

## C. PROCESSING FLOW

### 1. Introduction

The Claims Processing Subsystem consists of all manual and EDP processing steps necessary to approve or reject claims, credits, and adjustments; to generate payment instruments, remittance statements, and explanations of medical benefits for all approved claims; to process credits, and adjustments; to process approved requests for prior authorization; and to generate hard-copy responses to queries from providers and claims processing agency personnel.

The Claims Processing Subsystem is comprised of five discrete modules. Each module consists of a set of interrelated processing steps, some of which are manual while some are automated. The five modules and their basic functions are:

a. Input Preparation -- All input to the subsystem initially enters this module. The input is batched, microfilmed, manually edited for obvious rejection or disallowal, and translated into machine-readable format. The machine-readable data is then converted by EDP processing into a generalized claim transaction format acceptable for processing by other subsystem modules.

b. Disposition -- This module processes claim transactions which were placed in suspense during an earlier cycle through the subsystem. The object of this module is to take corrective action on claim transactions to release them for further processing.

c. Adjudication -- This module accepts as input the generalized claim transactions created by the Input Preparation Module and the claim transactions released from suspense by the Disposition Module. All claim transactions entering this module undergo processing which verifies the integrity of the claim transaction data; ensures that the provider and recipient were eligible at the time the services were rendered; verifies that the charges are consistent with the services performed; determines if limitations of service are being exceeded;

ensures that no claim has been previously approved that conflicts or duplicates one being currently processed; and verifies that any third-party liabilities have been discharged.

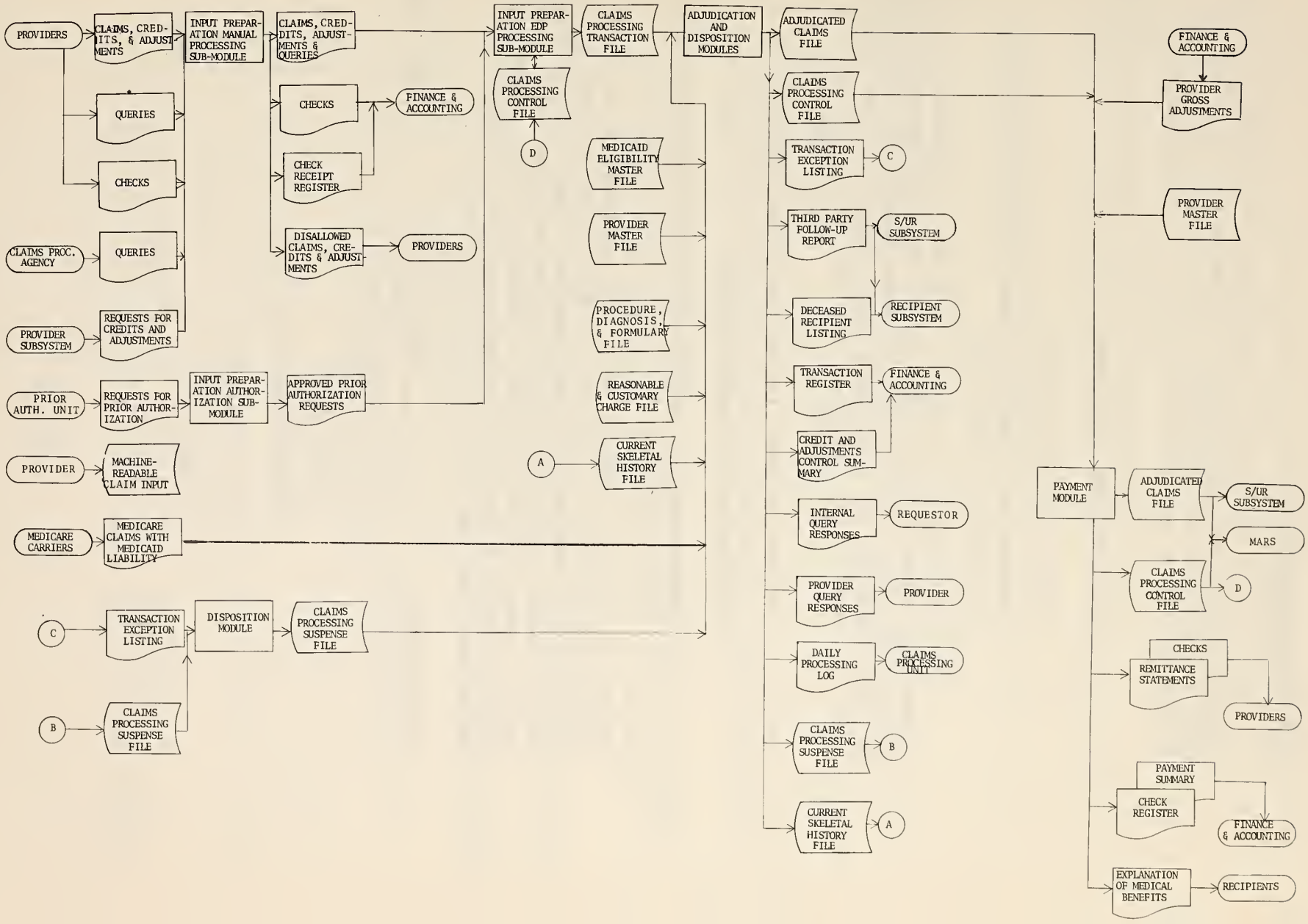
d. Distribution -- Output from the Adjudication module enters this module. Those claim transactions which have been adjudicated are collected in an adjudicated claims file; all others are placed into a suspense file. Reports of exceptions and errors, audit trails, and reports of instances requiring investigative follow-up are generated by this module. In addition, the calculation of claim payment amount is done by this module.

e. Payment -- Periodically, the adjudicated transactions collected by the Distribution Module enter this module. Remittance statements and checks for providers; payment summaries and a check register for finance and accounting; and explanations of medical benefits for recipients are all produced by this module. In addition, an Adjudicated Claims File is generated for use by other subsystems.

2. Functional Flow Diagram

The Claims Processing Subsystem Functional Flow Diagram found on the following page graphically depicts the overall processing flow through the Claims Processing Subsystem.

# Claims Processing Subsystem Functional Flow Diagram



## 3. Module Descriptions

The Claims Processing Subsystem is comprised of the modules listed on this page. The remainder of this section is devoted to descriptions of these modules. Each module is described in turn in the following manner:

a. A brief description of major functions performed and outputs produced.

b. Processing Flowcharts.

c. Process Step Definitions, including special exhibits as required.

The Processing Flowchart provides a schematic of the processing flow within each module indicating each discrete processing step. Individual process steps are identified on the flowchart by a process step number of the form:

CX.YY

where C indicates the Claims Processing Subsystem

X indicates the module number

YY indicates the number of a process step within that module.

Immediately following the Processing Flowcharts are descriptions of the activities or functions occurring at each process step within the module. These descriptions are presented on the Process Step Definition Sheet. The process step number provides a means of cross reference between the Processing Flowchart and the Process Step Definition Sheets.


| Module Number | Module Name | Page Number |
|---|---|---|
| C1 | Input Preparation | IV-17 |
| C2 | Disposition | IV-48 |
| C3 | Adjudication | IV-55 |
| C4 | Distribution | IV-73 |
| C5 | Payment | IV-81 |

## INPUT PREPARATION MODULE

### FUNCTIONS

The Input Preparation Module performs the following major functions:

a. Receives all source documents from both providers and from claims processing agency personnel.

b. Classifies and separates all source documents.

c. Distributes all source documents to the proper functional area.

d. Receives any machine-readable input that may be furnished by providers.

e. Assigns control numbers, batches, and microfilms all source documents (excluding those processed by other functional areas, e.g., correspondence from providers).

f. Provides machine-readable records for all batched source documents which are to be computer-processed to generate an "early identification" control file, if the early identification option is used.

g. All claims, credits, and adjustments are manually screened for rejection or disallowal prior to computer processing.

h. Prepares rejection and disallowal notices for those claims, credits, and adjustments which are rejected or disallowed during the manual screening process.

i. Returns to providers all rejected and disallowed claims, credits, and adjustments; and copies of approved or disapproved prior authorization requests.

j. Converts to machine-readable format all source documents accepted for computer processing.

k. Verifies, by computer, that all batches of source documents are acceptable for further processing.

l. Initiates computerized control data (or updates it, if the "early identification" option is used) which is used to monitor the progress of all claim transactions through the entire subsystem.

m. Places all machine-readable claim transaction data in a computer file which is suitable for entry into the adjudication module.

This module is divided into four submodules: three required and one optional. They are: manual processing, prior authorization, EDP processing, and, optionally, early identification. The manual processing submodule includes the processing of all input, except prior authorization requests, up to the point of converting the input to machine-readable format. The prior authorization submodule includes all the processing of prior authorization requests necessary to receive them, forward them to the Medical Assistance Unit for approval or disapproval, and prepare the approved requests for keying. The EDP submodule includes all processing involving either off-line or on-line EDP equipment.

The optional early identification submodule consists of those processing steps necessary to capture identifying data from all input before it undergoes manual processing. This submodule would normally be used only when there is an unusually long time interval separating the initial receipt of the input from its entry into the EDP processing submodule.

OUTPUTS

The Input Preparation Module produces the following major outputs:

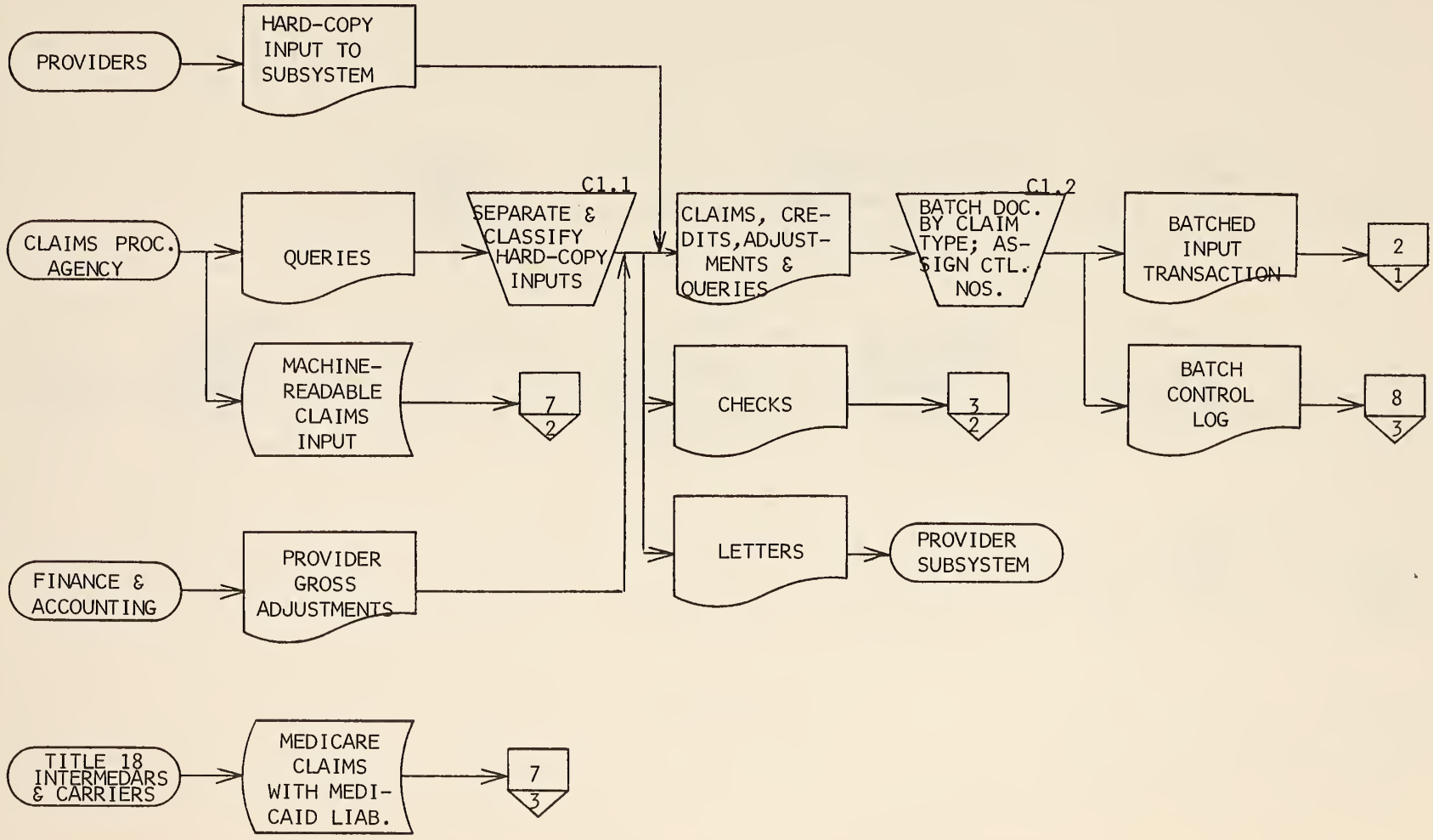
a. Claims Processing Transaction File -- this file is the result of the conversion of acceptable data to machine-readable form for further processing.

b. Disallowed and Rejected Claims, Credits, and Adjustments -- all claims, credits, and adjustments, which are disallowed or rejected as a result of manual processing, are returned to providers with an explanation and undergo no further processing.

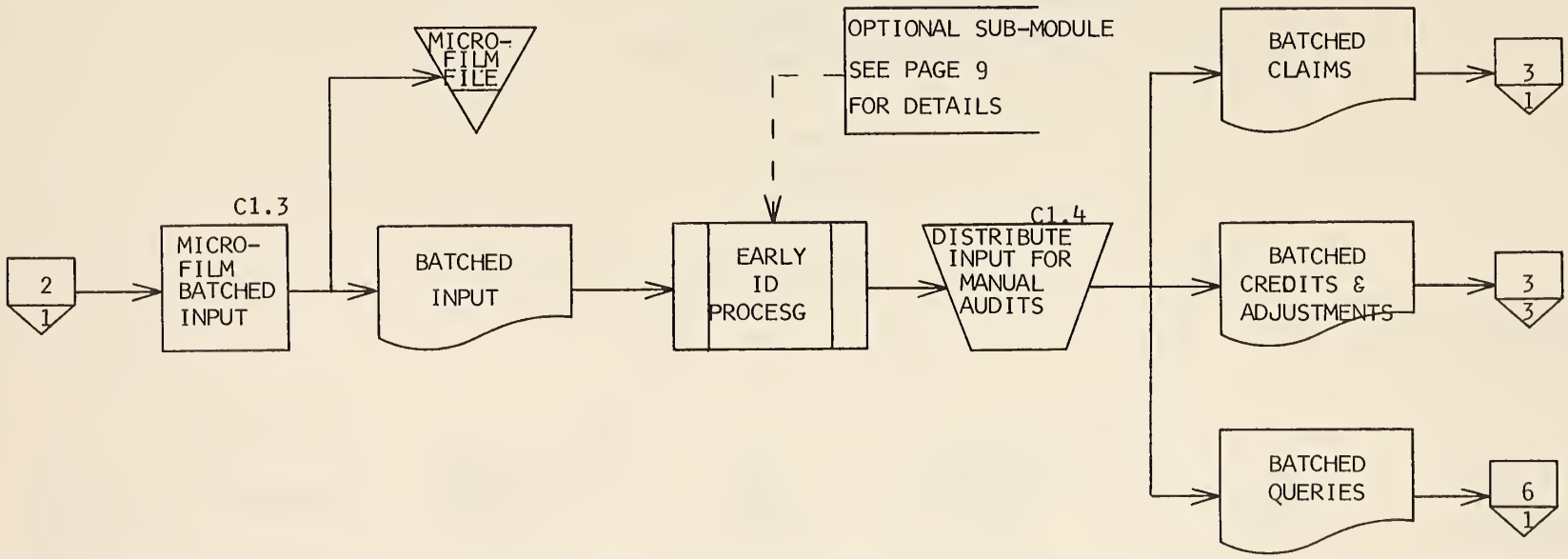
c. Input Control Listing -- a summary listing of all input with appropriate control total is produced for audit trail purposes.

d. Check Receipt Register -- All checks returned by providers are logged into a register which serves as a permanent record of returned checks.

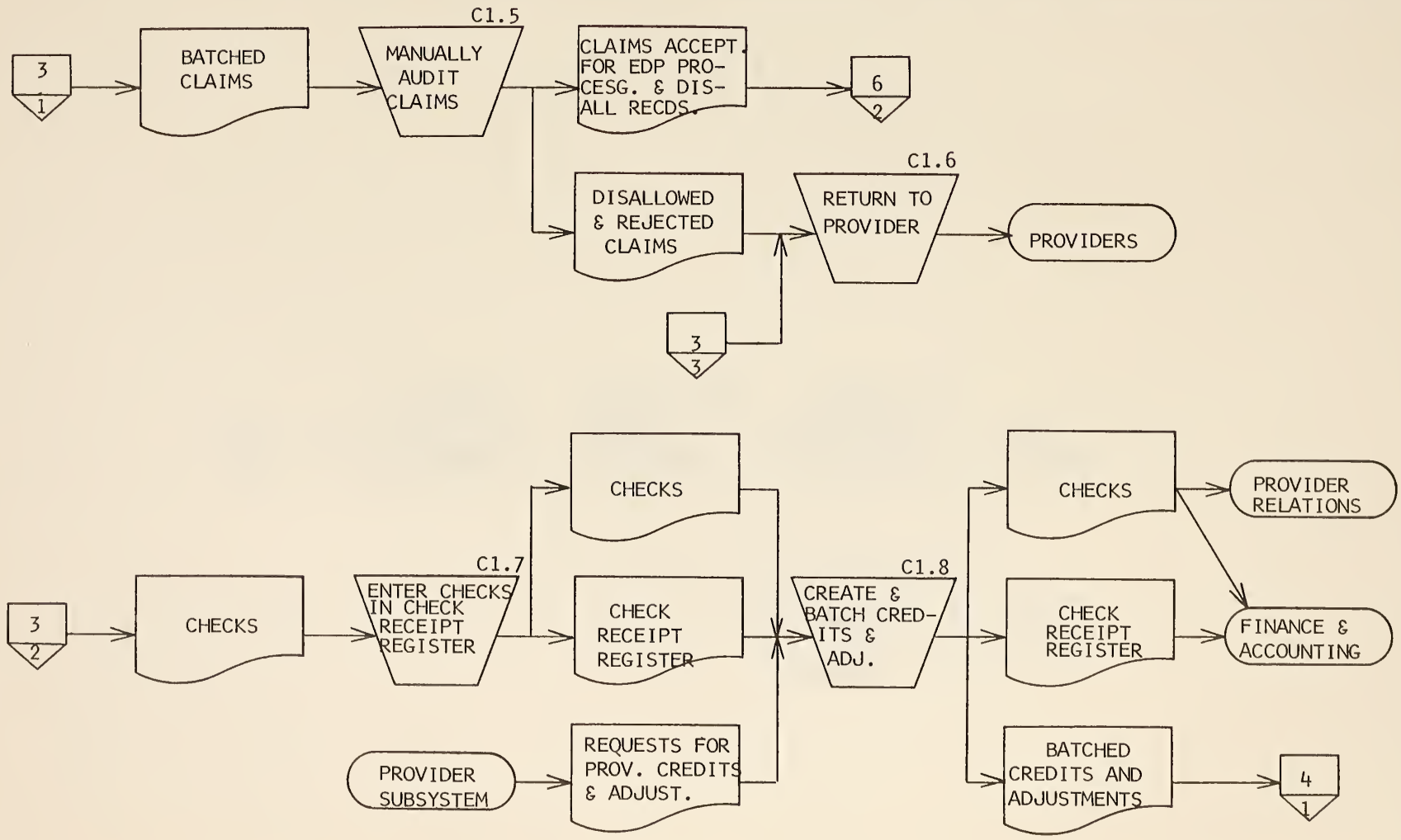
| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |



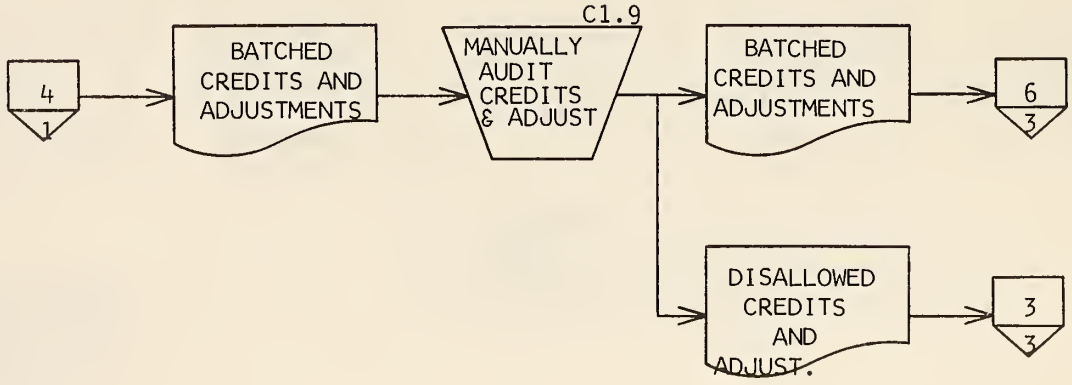
| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |

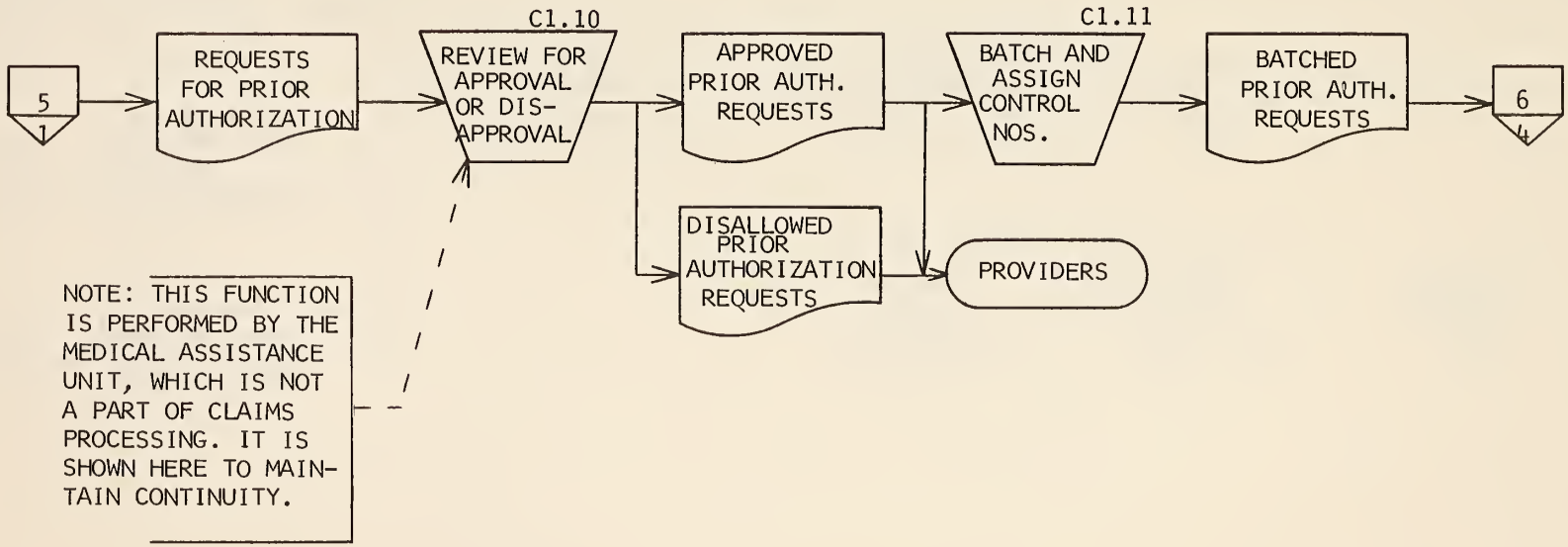


| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |

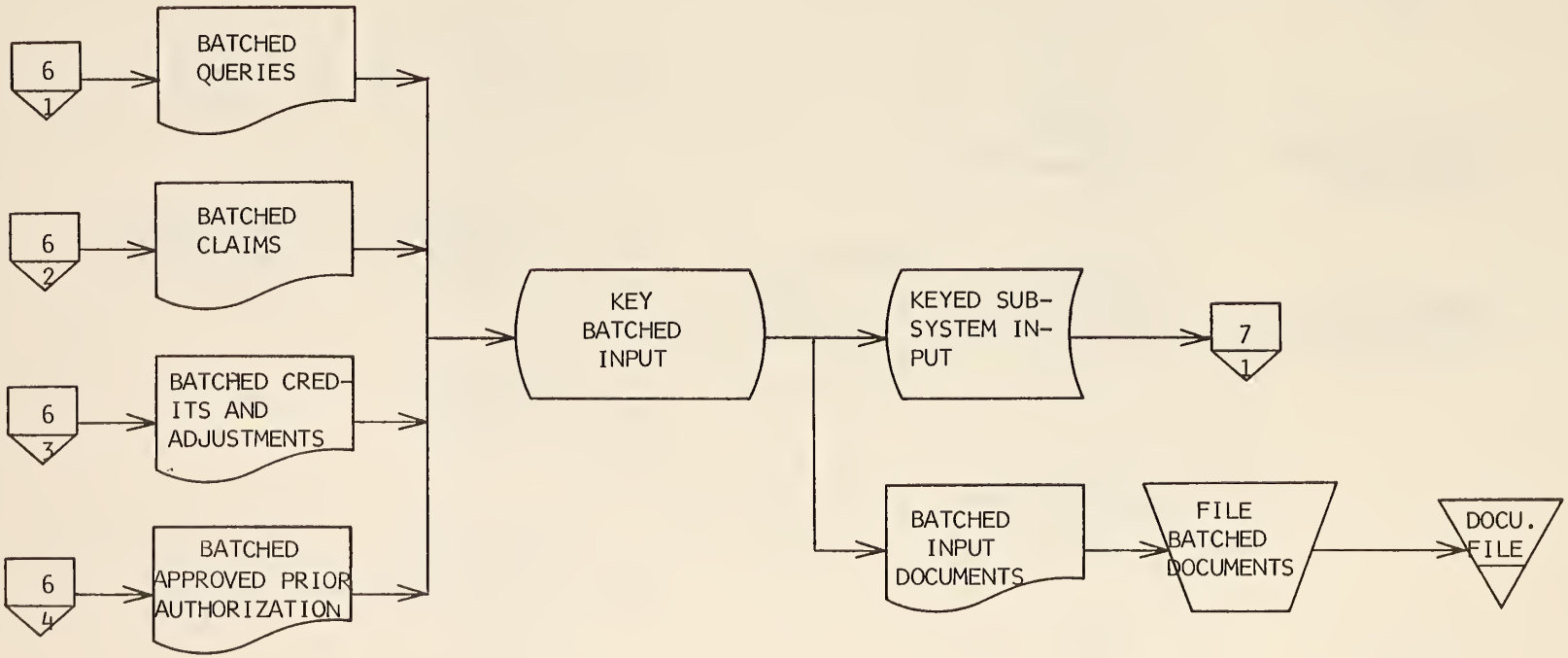


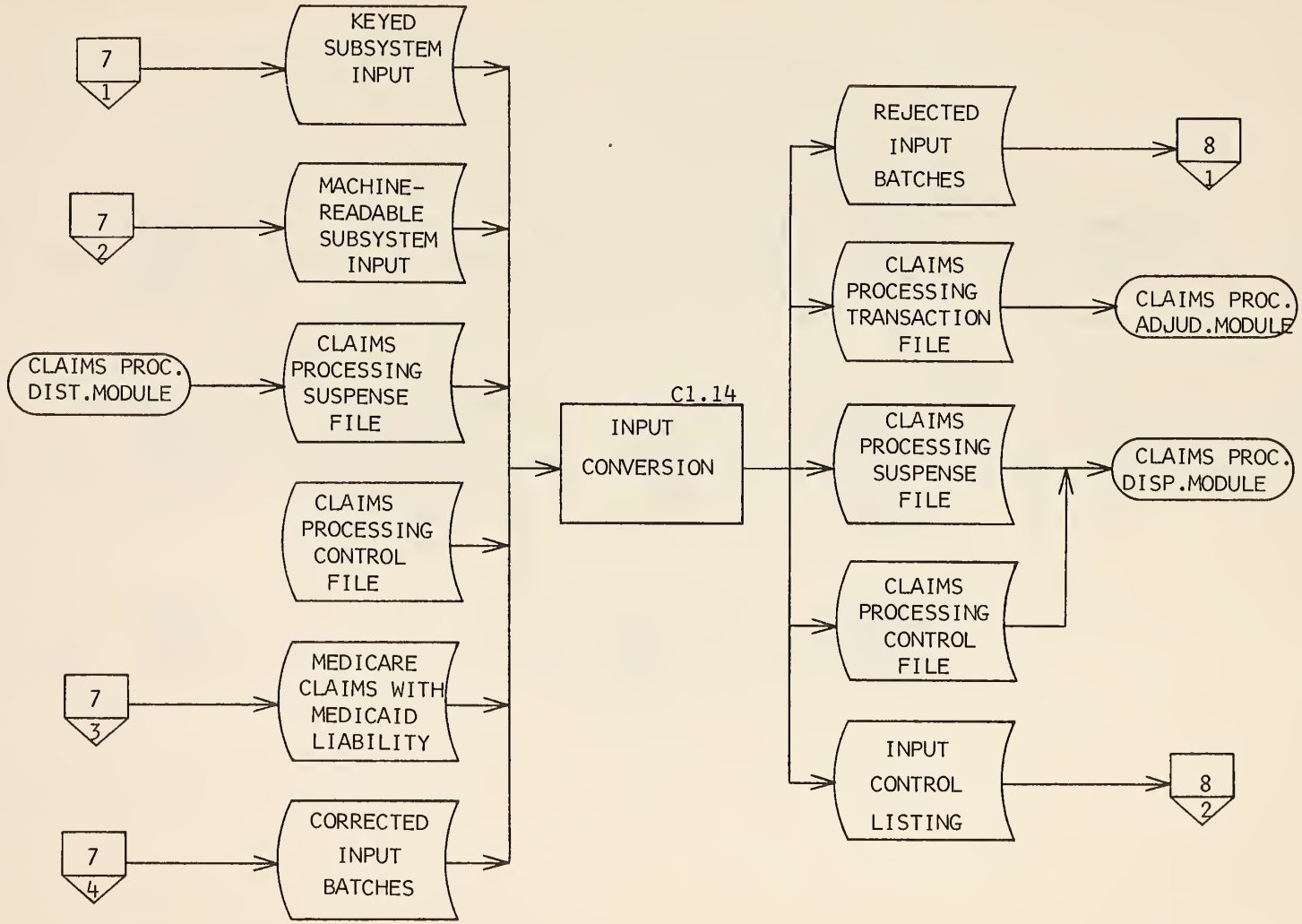
| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |



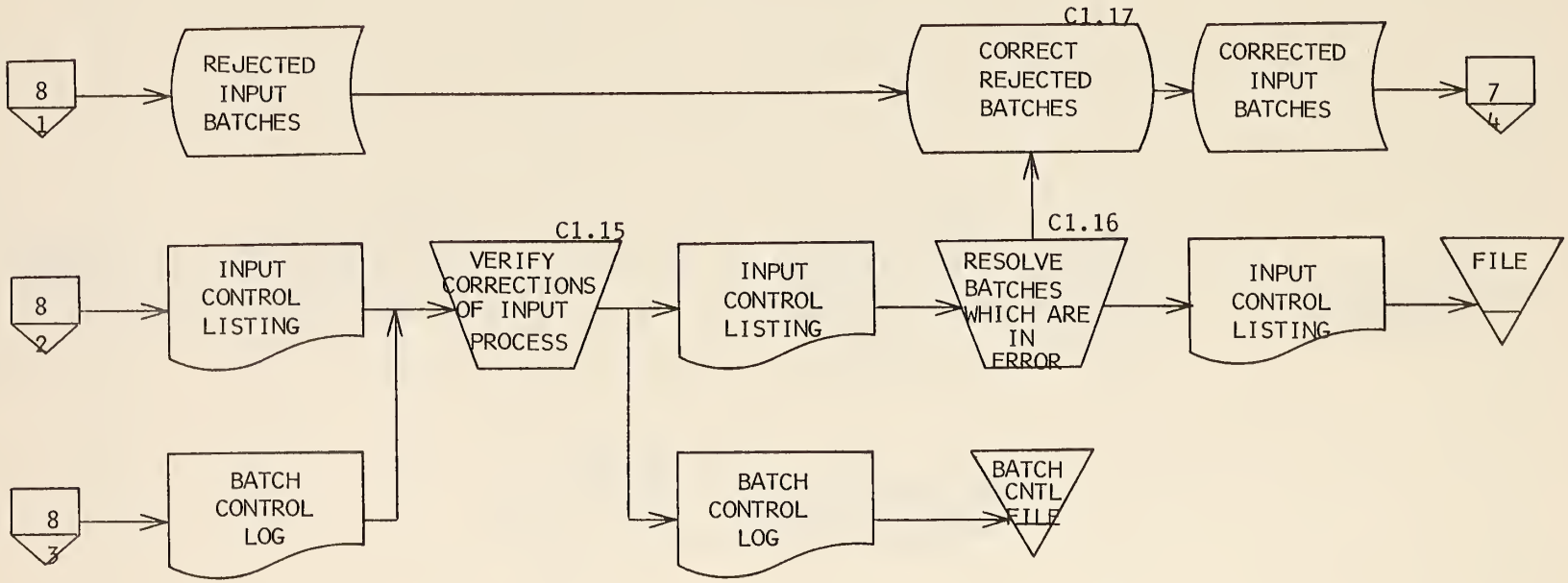

5
1
REQUESTS FOR PRIOR AUTHORIZATION
C1.10
REVIEW FOR APPROVAL OR DIS-APPROVAL
APPROVED PRIOR AUTH. REQUESTS
C1.11
BATCH AND ASSIGN CONTROL NOS.
BATCHED PRIOR AUTH. REQUESTS
6
4
DISALLOWED PRIOR AUTHORIZATION REQUESTS
PROVIDERS
NOTE: THIS FUNCTION IS PERFORMED BY THE MEDICAL ASSISTANCE UNIT, WHICH IS NOT A PART OF CLAIMS PROCESSING. IT IS SHOWN HERE TO MAINTAIN CONTINUITY.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |




7
1
KEYED SUBSYSTEM INPUT
7
2
MACHINE-READABLE SUBSYSTEM INPUT
CLAIMS PROC. DIST.MODULE
CLAIMS PROCESSING SUSPENSE FILE
CLAIMS PROCESSING CONTROL FILE
7
3
MEDICARE CLAIMS WITH MEDICAID LIABILITY
7
4
CORRECTED INPUT BATCHES
C1.14
INPUT CONVERSION
REJECTED INPUT BATCHES
8
1
CLAIMS PROCESSING TRANSACTION FILE
CLAIMS PROC. ADJUD.MODULE
CLAIMS PROCESSING SUSPENSE FILE
CLAIMS PROC. DISP.MODULE
CLAIMS PROCESSING CONTROL FILE
INPUT CONTROL LISTING
8
2

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |



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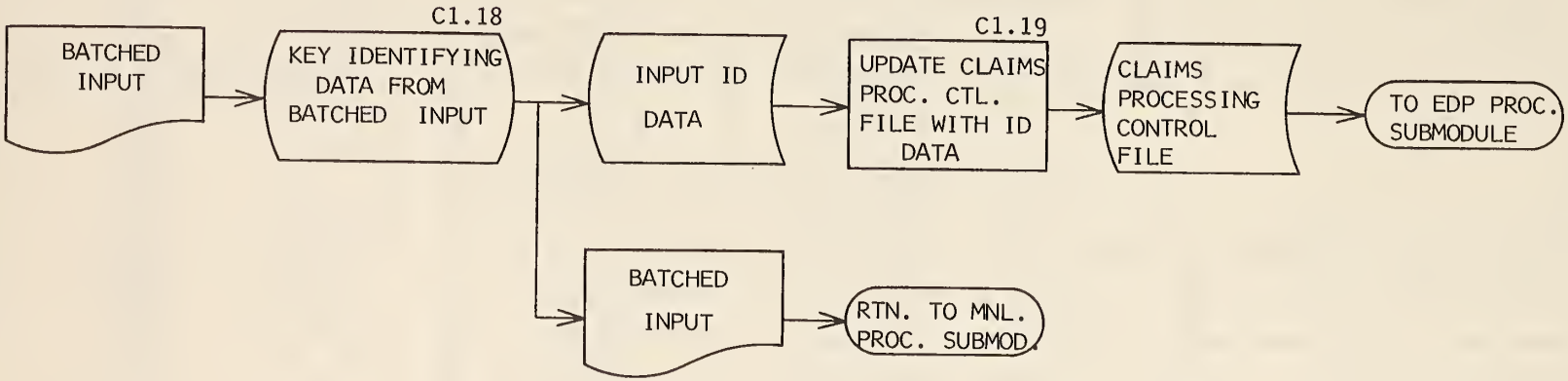
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - INPUT PREPARATION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM Claims Processing | | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| C1.1 | Mail Room | Incoming provider mail is separated and distributed to the unit responsible for further processing. Provider letters are forwarded to the provider subsystem. Checks from providers go to the credit and adjustment unit. Requests for prior authorization are sent to the medical assistance unit. The remaining input, consisting of claims, credits, adjustments, and queries, is held in the mail room for further processing (Step C1.2). |
| C1.2 | Mail Room | Claims, credits, adjustments, and queries are batched and a control number is assigned to each document. (See Exhibit IV-1 on page following for a more detailed explanation of this processing.) A batch control log entry is made for each batch of input documents. The log will be used to verify the accuracy and completeness of computer processing. The batches of documents are forwarded to the microfilm unit. |
| C1.3 | Microfilm Unit | All batches of documents are microfilmed in transaction control number sequence. After microfilming, the batches are sent to the process control supervisor, unless the early identification option is used. If early identification is used, the batches are sent to the data preparation unit (see Steps C1.18 and C1.19). |

## DOCUMENT BATCHING PROCEDURES

All documents are separated by category (claim, credit, adjustment, or query). The documents in each category are then broken down into groups by type of provider and service (e.g. hospital inpatient, pharmacy, physician). Each group is then grouped in batches of from 25 to 50 documents. The number per batch depends on the type of document. Each batch is then assigned a control number. Each document in the batch receives a sequential number which, when appended to the control number of the batch, becomes the unique transaction control number for the document. If ledger-type documents, upon which more than one claim can be entered, are used, a preprinted line number appearing on the document serves to uniquely identify each claim on the document.

The structure of the transaction control number is as follows:

YDDDXNNNNSSLL

a. YYDD is the Julian date upon which the batch was created.

b. X is a unique letter identifying the type of document (e.g. pharmacy, home health, physician).

c. NNNN is a number which uniquely identifies each batch of similar documents. Certain ranges should be reserved to identify different type documents (e.g. 001-699 for claims, 700-799 for credits, 800-899 for adjustments, 900-999 for prior authorization).

d. SS is a number assigned sequentially to each document in a batch.

e. LL is the preprinted line number appearing on each line of ledger-type claim documents (LL is assumed to be ØØ for documents which can accommodate only one claim).

Example:

Assume "F" is the unique letter assigned to pharmacy claims.

A batch identified by the number 2027F0068 is known to be the 68th batch of pharmacy claims assembled on January 27, 1972. A document bearing the number, 2027F006812 is the 12th document in that batch. Assuming a ledger-type claim document, a claim identified by the number 2027F00681207 is known to be that claim appearing on the seventh line of the claim form.

A batch control sheet is made up for each batch of documents. The sheet has the number of the batch and the number of documents in the batch. There is also space for the initials or identifying

numbers of the various personnel, such as key-punch operator, verifier, manual auditor, who process the batch. Information from the batch control sheets are summarized in the batch control log.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM Claims Processing | | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| C1.4 | Process Control Supervisor | The batches are distributed for manual processing as follows:<br>a. Claims are passed to the claims audit unit (which is divided into sub-units, each of which processes a unique type of claim).<br>b. Credits and adjustments are forwarded to the credit and adjustment unit.<br>c. Queries are sent to the data preparation unit.<br>Entries are made in the batch control log accounting for each batch's location. |
| C1.5 | Claims Processing Unit | Claims are manually audited for conditions which preclude further processing (See Exhibit IV-2 on the following page for audit details). Those claims which cannot be processed further are removed from their batch and sent to the mail room with an explanation of the disallowal or rejection. An entry is made on the batch control sheet to account for the removed claims. The batches are then forwarded to the data preparation unit. |

## MANUAL CLAIMS AUDIT

Claims are audited manually in order to disallow or reject at once those claims which will obviously be suspended by the computer processing. Typical reasons for disallowal or rejection are:

- Missing recipient ID number (rejection)
- Missing diagnosis (rejection)
- Missing required signatures (rejection)
- Obviously non-covered services (disallowal)
- Missing dates of service (rejection)
- Missing procedure(s) (rejection)
- Services requiring but having no indication of, prior authorization (disallowal).

Each auditor should process a claim completely. This is preferable to having specialized auditors who examine only a part of each claim. Auditors should, however, audit only one type of claim.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | PROCESS STEP DEFINITION |
|---|---|

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C1.6 | Mail Room | All manually disallowed and rejected claims, credits, and adjustments are returned to the provider with an attached letter of explanation. |
| C1.7 | Credit and Adjustment Unit | All checks received from providers are logged in a check receipt register. The register identifies the provider, the check number and the amount, and the indicated reason for the return, if present. |
| C1.8 | Credit and Adjustment Unit | Using information from the check receipt register, credits and/or adjustments are created which will properly update the providers' accounts. The credits and adjustments are then batched and assigned control numbers (See Step C1.2). The transaction control number of each credit or adjustment is entered on the check receipt register. The register and checks are then forwarded to the Finance and Accounting Department. All checks which can not be resolved using the data available within the Claims Processing Subsystem are forwarded to the Provider Relations Unit for resolution. The Provider Relations Unit initiates requests for credits and adjustments as a result of the resolution of returned checks, as well as originating requests. The requests are received and processed during this step in a manner similar to returned checks. |

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C1.9 | Credit and Adjustment Unit | All credits and adjustments are manually audited in a manner similar to claims (see Step C1.5). Those disallowed or rejected are sent to the mail room. After recording their removals on the batch control sheet, the batches are forwarded to the data preparation unit. |
| C1.10 | Medical Assistance Unit | Requests for prior authorization are reviewed. Approved and rejected requests are mailed to the provider. (This process step is not part of claims processing. It is shown to maintain continuity.) A copy of all approved requests is sent to the claims processing unit. |

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C1.11 | Claims Processing Unit | Approved prior authorization requests are batched and assigned control numbers in a manner similar to claims (Step C.1.2). The batches are then forwarded to the data preparation unit. |
| C1.12 | Data Preparation Unit | The batches of input documents are keyed. After all input has been keyed, the batches are filed (Step C1.13) and the keyed data is sent to the computer processing unit. |
| C1.13 | Filing Unit | All batches of input documents are filed. The retention of the filed batches depends on various State and Federal regulations, and the extent of microfilming. |
| C1.14 | Data Processing | All keyed input, machine-readable input from providers, Medicare claims with Medicaid liability (crossovers) from Title XVIII intermediaries and carriers, and corrected input batches from prior processing cycles enter the computer system (see Exhibit IV-3 for details). |

## INPUT CONVERSION PROCESSING

The input conversion routine accepts four basic inputs:

1. Keyed subsystem input.

2. Machine readable subsystem input.

3. Medicare crossovers.

4. Corrected input batches.

In additon, two on-going EDP files are used in the processing. The two files are: (1) the Claims Processing Suspense File and (2) the Claims Processing Control File. Five outputs are produced; a Claims Processing Transaction File, a file of rejected input batches, an Input Control Listing, and updated versions of the Claims Processing Suspense and Control Files.

The keyed input and the corrected input batches are processed to ensure that each batch is composed of the correct number of properly formatted claim transactions. Any batch which is determined to be incorrect is placed in a rejected input batch file. The claim transactions in all good batches are used to create a Claims Processing Transaction File which is the principal work file used by the subsystem.

Approved prior authorization requests entering the subsystem are placed in the Claims Processing Suspense File for subsequent matching with incoming claims which require prior authorization.

Any input claim which indicates a need for prior authorization causes a search to be made of the Claims Processing Suspense File for an approved prior authorization with a matching approval number. A matching check is made on billed and approved services. If no prior authorization is found, or if there is a disparity between billed and approved services, the claim is flagged for subsequent review.

As the various inputs are processed, the Claims Processing Control File is continually updated to reflect the proper status of all claim transactions in the system.

Machine-readable input and Medicare crossovers receive computer generated transaction control numbers. The numbers assigned are within a range not allowed for keyed input.

An Input Control Listing is produced which summarizes all claim transactions entering the subsystem, provides beginning control totals, and details the error detected which caused rejection of a batch.

The Claims Processing Transaction File will serve as input to the Adjudication Module. The rejected input batches and the Input Control Listing are returned to the data preparation unit. The updated Claims Processing Suspense and Control Files are released to the Disposition Module for further processing.

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C1.15 | Data Preparation Unit | The Batch Control Log and Input Control Listing are checked to ensure that all logged batches are accounted for by the computer processing procedure. The Batch Control Log is then updated to reflect the changed status of all batches. |
| C1.16 | Data Preparation Unit | The Input Control Listing is analyzed to determine the reason for rejection of batches. Data needed to correct the batches is entered on the listing. |
| C1.17 | Data Preparation Unit | Using the correction data from the Input Control Listing, the rejected batches are corrected and released as input to the next input conversion cycle. |

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM | Claims Processing | |

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| | | The next two steps comprise the optional early identification sub-module. |
| C1.18 | Data Preparation Unit | Enough data from each input document (e.g. Recipient ID No., Provider No., Transaction Control No., Dates of Service) to allow permanent identification of the document is keyed. The keyed data is sent to the computer processing unit. The batched input documents are forwarded to the process control supervisor. |
| C1.19 | Data Processing | The keyed identification data updates the Claims Processing Control file. Each transaction is identified on the file as "in manual processing". |

## DISPOSITION MODULE

### FUNCTIONS

The Disposition Module performs the following major functions:

a. Analyzes the Transaction Exception Listing prepared by the Distribution Module during the previous processing cycle and determines what action must be taken to cause excepted claim transactions to undergo adjudication.

b. Codes corrective action data for excepted claim transactions.

c. Converts the coded corrective action to machine-readable format.

d. Applies the corrective actions to the claims transactions in the Claims Processing Suspense File.

e. Creates two output files: one consisting of suspense claim transactions for which no corrective action was taken and the other comprised of those claim transactions to which corrective actions were applied.

f. Generates an audit trail which indicates all actions taken on exception claim transactions.

### OUTPUTS

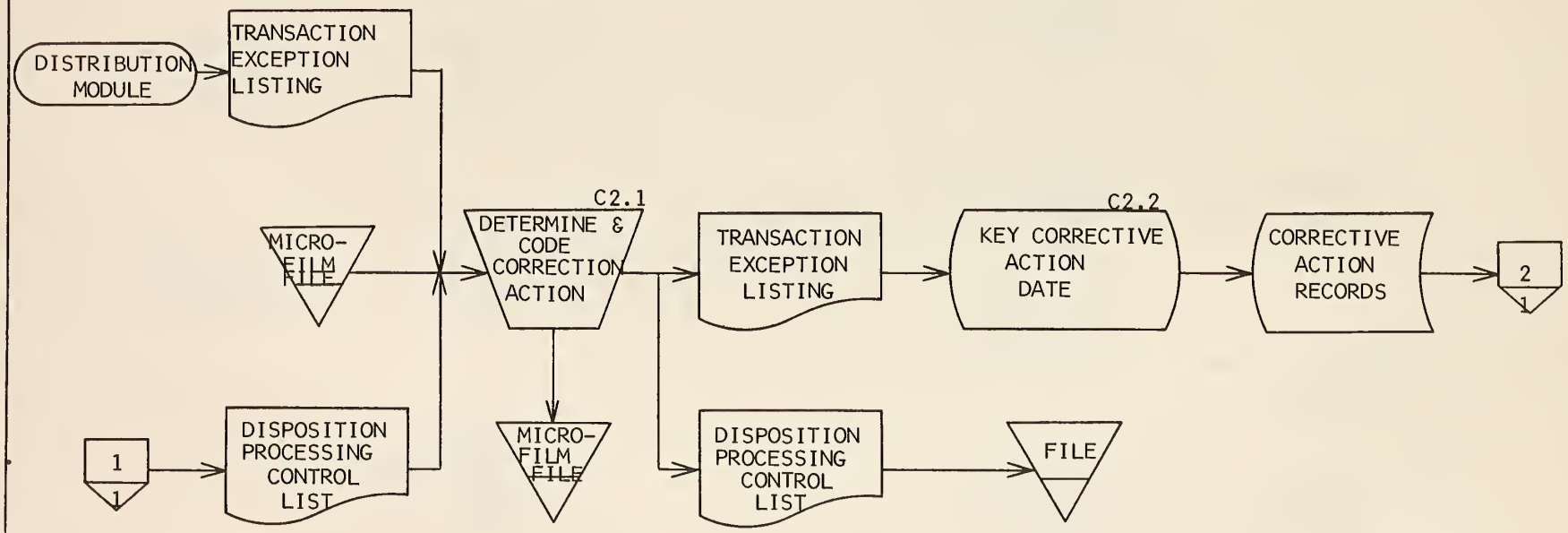
The Disposition Module produces the following major outputs:

a. Claims Processing Suspense File -- those claim transactions for which no corrective action was taken remain in a suspense file awaiting future action.

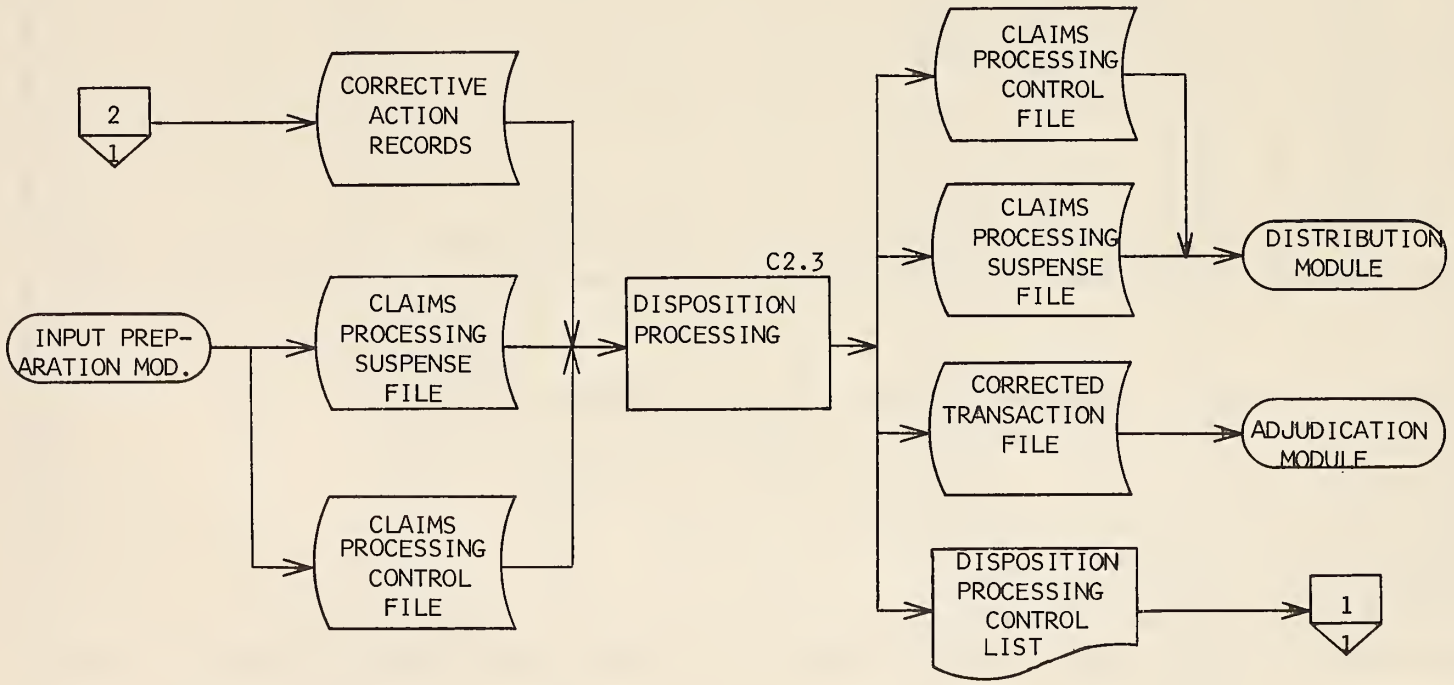
b. Corrected Claims Transaction File -- all transactions which underwent corrective action are placed in a file which will enter the adjudication module.

c. Disposition Processing Control List -- a report indicating all corrective actions taken and their effect.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING - DISPOSITION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING - DISPOSITION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | PROCESS STEP DEFINITION |
|---|---|
| SUBSYSTEM Claims Processing | |

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C2.1 | Data Processing | Using the Transaction Exception Listing and the Disposition Processing Control List from the previous processing cycle and the microfilm file of claim transactions, an attempt is made to apply corrective action to all excepted transactions (see Exhibit IV-4 on following page for details of this procedure). The corrective actions are coded directly on the Transaction Exception Listing which is then sent to the data preparation unit. The Disposition Processing Control List is filed. |
| C2.2 | Data Preparation Unit | Corrective action data, noted on the Transaction Execption Listings is keyed producing a file of corrective action records. |

## MANUAL DISPOSITION

In general, there are four corrective actions which may be taken for a suspense claim transaction. They are:

a. Change one or more data fields, whose contents is erroneous, in the claim transaction.

b. Flag the claim transaction as disallowed.

c. Delete the claim transaction from the system (e.g., the transaction contains so much erroneous data that it is unprocessable).

d. Flag the claim transaction to ignore certain error conditions (override code).

The proper corrective action code is entered on the Transaction Exception Listing as well as any other data needed (e.g. the new contents of a data field, the error condition to be overridden).

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | PROCESS STEP DEFINITION |
|---|---|

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C2.3 | Data Processing | The corrective action records are editted for errors prior to be used to update the Claims Processing Suspense File. Those suspense transactions with matching records are altered with the corrective action data, their error flags are cleared, and they become input to the Adjudication Module. All other suspense transactions are placed in a new suspense file. The Disposition Processing Control List is printed. This list displays the results of all corrective actions including those not processed because of edit errors. The Claims Processing Control File is updated to reflect all changes in the status of individual claim transactions. |

## ADJUDICATION MODULE

### FUNCTIONS

The Adjudication Module is the heart of the Claims Processing Subsystem. The final determination to pay or disallow is made here. The Adjudication Module performs the following major functions:

a. Validates the data contained in each claim transaction.

b. Verifies that all procedures are valid.

c. Makes extensive checks as to the compatibility of procedures and diagnoses.

d. Ensures that the provider was eligible at the time the service was rendered.

e. Verifies that the provider is authorized to perform the service.

f. Assigns reimbursement rates to all claim transactions.

g. Determines that the recipient was eligible for the particular category of service at the time it was rendered.

h. Checks for the possibility that a third-party liability may exist which was not entered on the claim.

i. Verifies that the claim does not duplicate or conflict with one adjudicated previously (including a prior one in the current process cycle).

j. Ensures that a claim is not for services in excess of limitations imposed by program regulations or does not exceed the Medicare reasonable and customary charge for that service.

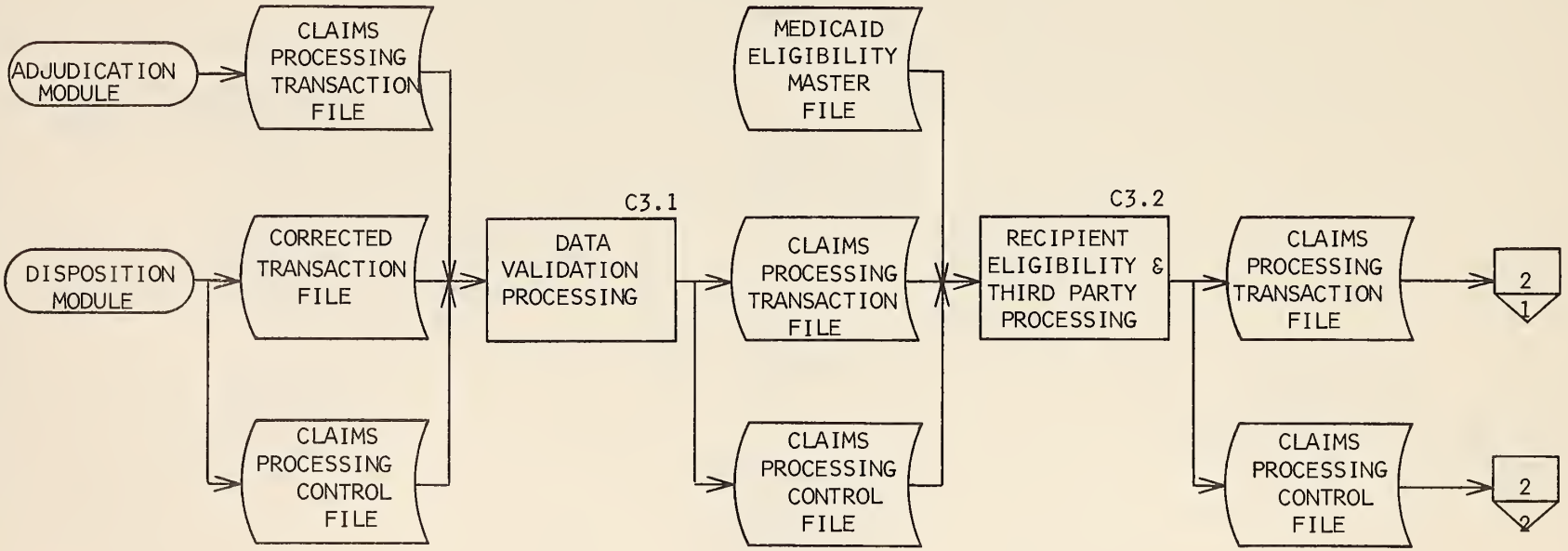
k. Continuously updates the Claims Processing Control File to reflect changing claim transaction status and control totals.

### OUTPUTS

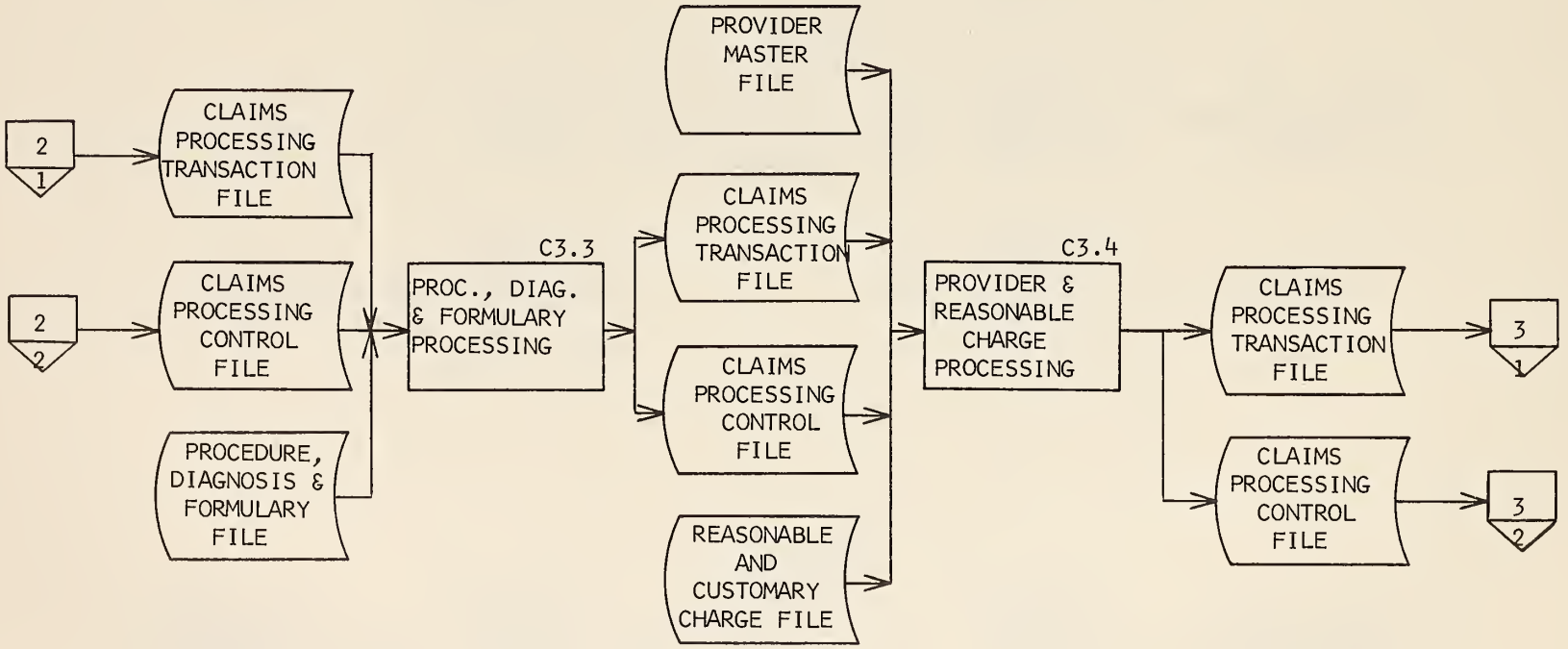
This module has only two outputs. The first is the Claims Processing Transaction File which enters the module and is continuously updated at various process steps with error codes, Provider Master File data, Medicaid Eligibility Master File data, etc. When

released by the module, the file serves as input to the Distribution Module. The other is the Current Skeletal History File which is used for duplicate and conflicting claim detection and then is updated with all adjudicated claims.

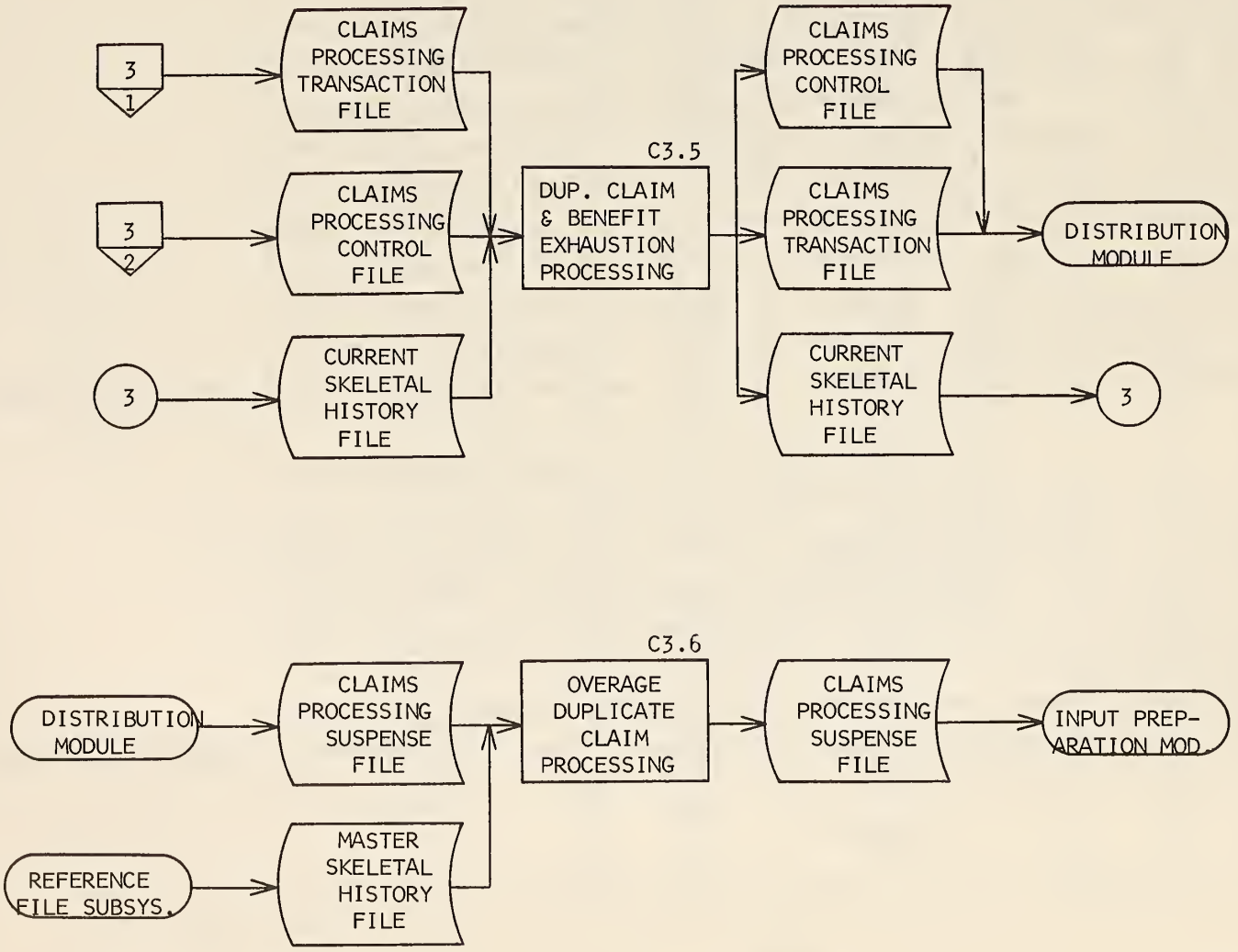
| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - ADJUDICATION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - ADJUDICATION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - ADJUDICATION MODULE | |



SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C3.1 | Data Processing | Transactions from the Claims Processing Transaction File and the Corrected Transaction File are accepted and edited for validity and consistency of data (see Exhibit IV-5 on following page for details). Each error detected in a transaction is coded into the record. The Claims Processing Control File is updated to reflect changes in transaction status. The transaction file is passed to the recipient eligibility - third-party processing routine at the conclusion of this step (see Step C3.2). |
| C3.2 | Data Processing | The claim transactions are next checked against the recipient eligibility master to verify eligibility and third-party data (see Exhibit IV-6 following for details). All detected error conditions are coded into the transaction. If a State elects to apply optional recipient deductibles on non-institutional services, the deductible amounts are calculated here. Election of this option would require billing the recipient for the deductible as the maximum deductible is limited to a monthly amount. Verification of premium payments or enrollment fees by medically needy recipients can also be performed here. All entering queries cause records to be generated which contain data from the Medical Eligibility Master File needed to produce proper replies to the query. After all transactions have been processed, the transaction file is released to the procedure, diagnosis, and formulary process step (C3.3). The Claims Processing Control File continues to be updated. |

## DATA VALIDATION PROCESSING

The following is a representative listing of the edits made during this processing step:

a. All fields defined as numeric must contain only numeric data.

b. All fields defined as alphabetic must contain only alphabetic data.

c. All dates must be valid and reasonable (e.g. service dates could not be at some future time).

d. All data items which can be obtained by arithmetic manipulation of other data items should agree with the results of the manipulation (e.g. cross foots and totals).

e. All coded data items should consist of valid codes.

f. Any data items containing self-checking digits (e.g. Recipient ID No.) should pass the specified check-digit test.

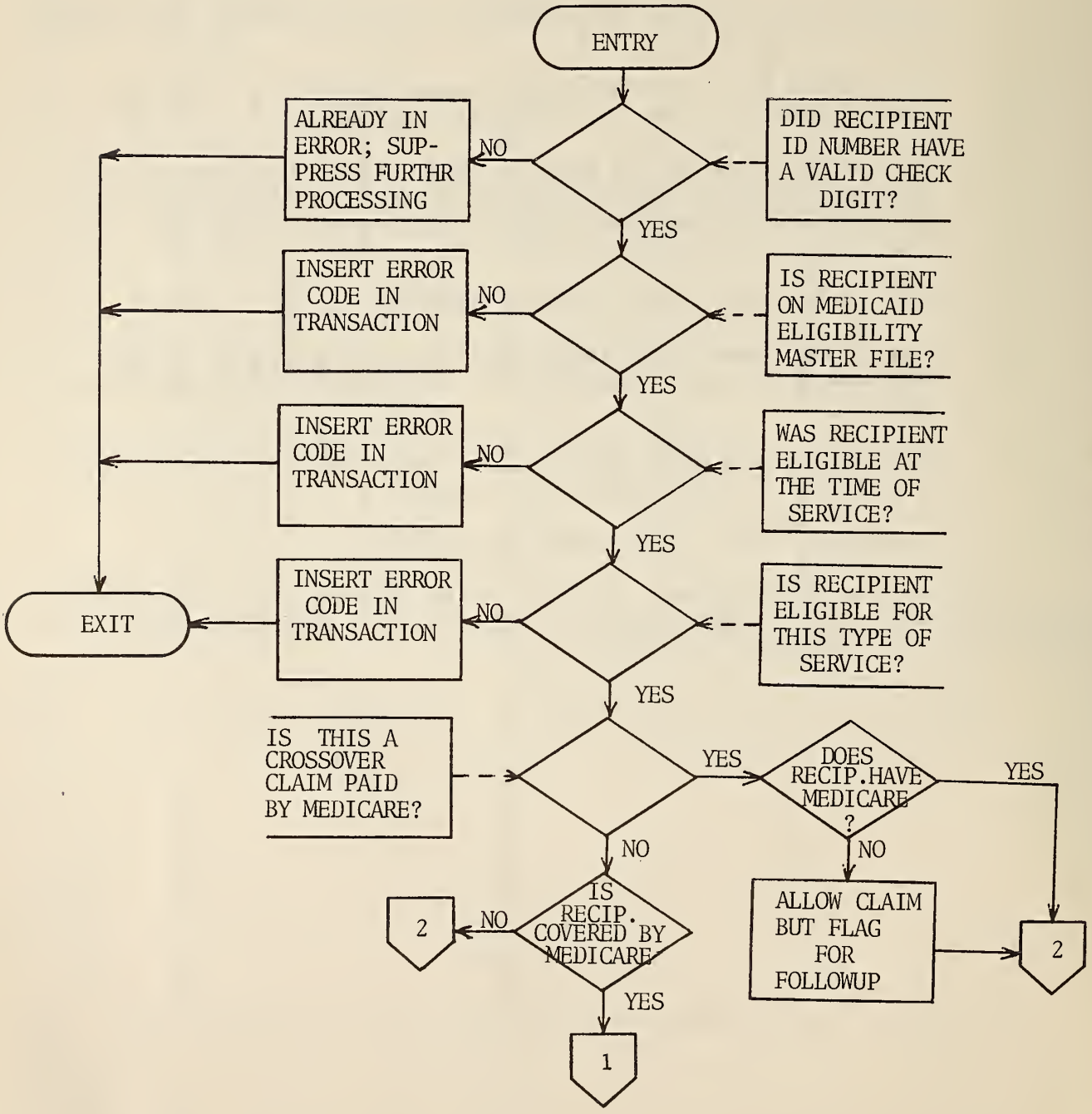
g. Numeric items with definitive upper and/or lower bounds should be within the proper range.

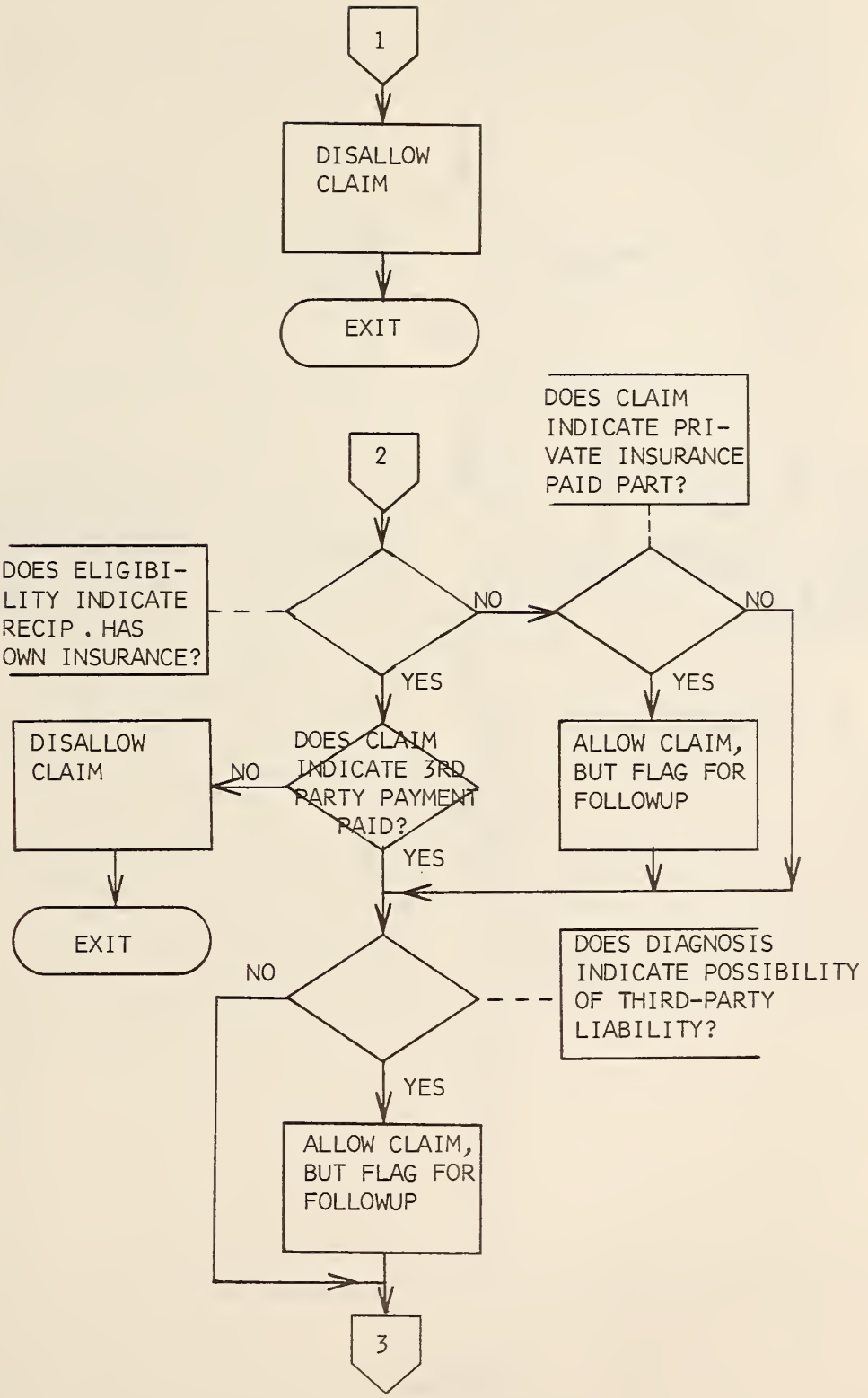
h. Mandatory data items must be present.

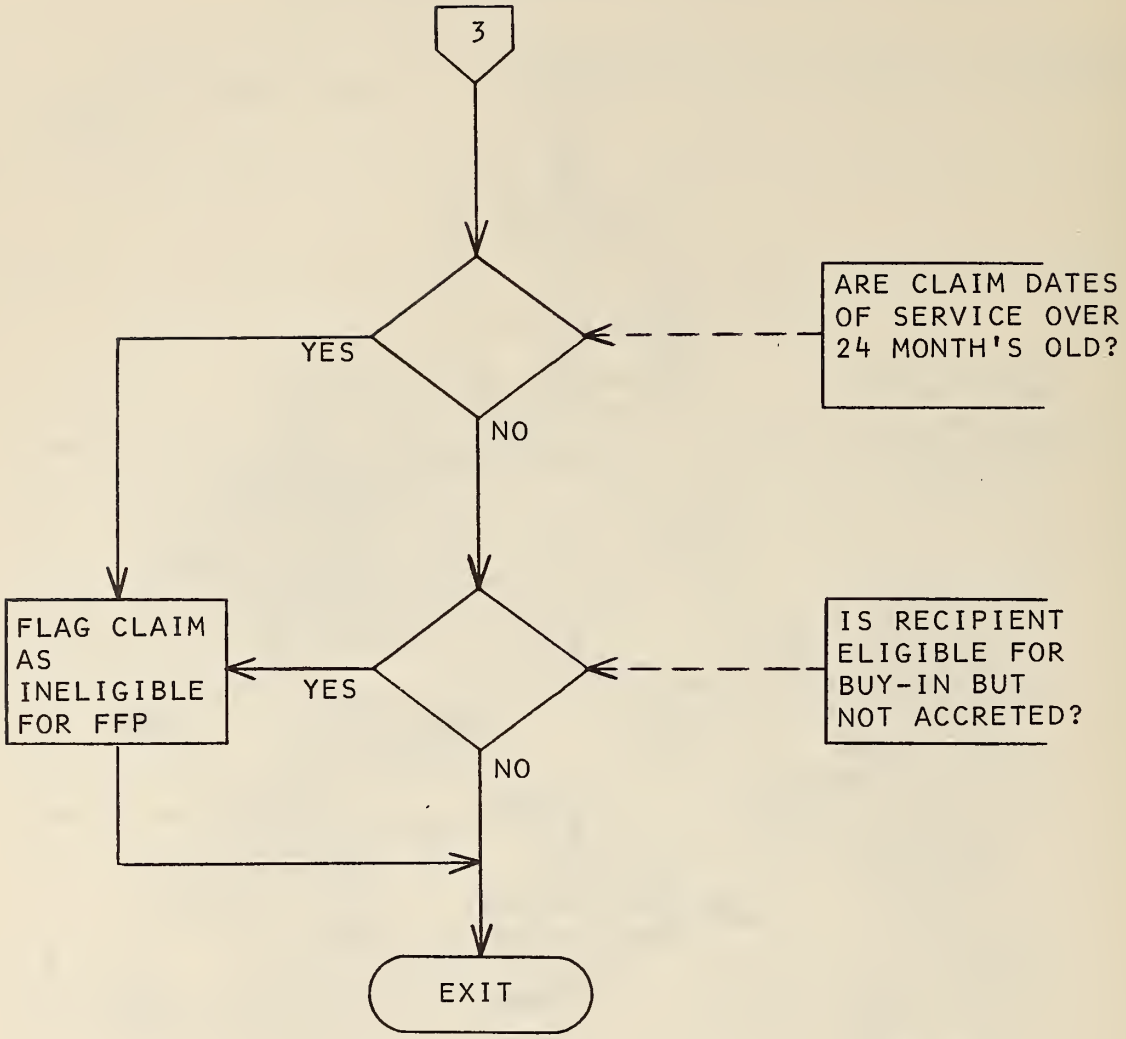
During this processing, the detection of one error does not preclude continuing further edits. All error conditions should be detected in one processing cycle.

## RECIPIENT ELIGIBILITY AND THIRD PARTY PROCESSING

The general logic of this processing step is shown in the following chart:




1
DISALLOW CLAIM
EXIT
2
DOES CLAIM INDICATE PRI-VATE INSURANCE PAID PART?
DOES ELIGIBI-LITY INDICATE RECIP . HAS OWN INSURANCE?
NO
NO
YES
YES
DISALLOW CLAIM
NO
DOES CLAIM INDICATE 3RD PARTY PAYMENT PAID?
ALLOW CLAIM, BUT FLAG FOR FOLLOWUP
YES
EXIT
NO
DOES DIAGNOSIS INDICATE POSSIBILITY OF THIRD-PARTY LIABILITY?
YES
ALLOW CLAIM, BUT FLAG FOR FOLLOWUP
3


3
ARE CLAIM DATES OF SERVICE OVER 24 MONTH'S OLD?
YES
NO
FLAG CLAIM AS INELIGIBLE FOR FFP
IS RECIPIENT ELIGIBLE FOR BUY-IN BUT NOT ACCRETED?
YES
NO
EXIT

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C3.3 | Data Processing | Each claim transaction is edited for procedure and diagnosis validity (see Exhibit IV-7 on the following page for details). In addition, all procedures which may be priced by fee schedules are priced by this routine. This includes the verification of the provider's billed price (and reduction, if necessary). The billed price of pharmacy prescriptions are processed against the formulary file in a manner similar to that undergone by procedures that are priced by fee schedules. Any optional copayments or coinsurance required by the State are computed at this point. Error codes are inserted into transaction records, when appropriate. The updating of the Claims Processing Control File continues. |
| C3.4 | Data Processing | All transactions next undergo editing for provider and reasonable charge exceptions. All pricing of procedures which is dependent on the identity of the provider occurs in this routine (see Exhibit IV-8 for details). All charges submitted by individual practitioners (i.e., physicians, dentists, osteopaths, podiatrists) are checked to see that a payment to a practitioner does not exceed his reasonable charge recognized under Title XVIII, Part B, or the area prevailing charge under Title XVIII, Part B, for similar services in the same locality. As in all steps of this module, error codes are inserted in transactions when appropriate and the Claims Processing Control File is updated. |

## PROCEDURE AND DIAGNOSIS CHECKING

The procedure, diagnosis, and formulary processing routine makes various checks on the validity of procedures, etc, and on the relationship of procedure and diagnosis. Included in the edits are the following:

a. The procedure code must be valid.

b. The procedure must be consistent with the diagnosis.

c. The procedure must be consistent with the recipient's age.

d. The procedure must be consistent with the recipient's sex.

e. The procedure must be consistent with the place of service.

f. The procedure must be consistent with the category of service.

g. The diagnosis code must be valid.

h. The diagnosis must be consistent with the recipient's age.

i. The diagnosis must be consistent with the recipient's sex.

j. Combinations of procedures which indicate a need for manual pricing intervention.

k. The billed amount differs from the allowable fee schedule amount by more than a certain percentage (either above or below). This indicates (1) possible incorrect procedure, (2) possible incorrect billed amount. (3) when too high, possible need for individual consideration.

## PROVIDER AND REASONABLE CHARGE PROCESSING

The following list covers the minimum requirements for provider and reasonable charge edits:

a. The provider must be on the Provider Master File.

b. The provider must be eligible to render service during the period covered by the claim.

c. The provider type must be consistent with the diagnosis and procedures.

d. There must be no Provider Exception Indicator code in the provider master record.

Pricing of all transactions for which the identity of the provider is needed is done here. Examples are:

a. Hospital per diem rates.

b. Long term care (SNF and ICF) per diem rates.

c. Practitioner's usual and customary charges.

d. Area prevailing rates.

e. Medicare practitioner's usual and customary charges.

f. Medicare area prevailing charges.

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C3.5 | Data Processing | During this process step, all claims are checked against the Current Skeletal History File for duplication of, or conflict with, claims already adjudicated (see Exhibit IV-9 following this page for details). If claim filing limitations are exceptionally liberal or claim volume is quite large, it may be impractical to maintain a large enough history file to always check older claims for duplication or conflict. If a claim is older than the available history, a special error code is inserted in the record for use in a special "over age duplicate check" (see Step C3.6). The history records for each recipient are summarized to determine service unit usage during this step. Any current claim which would cause an excessive use of service units, which are limited by program regulations, is flagged as an exception.<br><br>This is the last processing step in the adjudication module. Any transaction which leaves this routine with no detected exceptions is considered to be allowed for payment. Those claims approved for payment are used to create additional history records which are inserted in the history file. |

## DUPLICATE AND CONFLICTING CLAIM PROCESSING

This routine should include, as a minimum, the following checks:

a. The dates of service of an institutional claim should not overlap with the dates of service of another (i.e. it is not likely for a recipient to be in two institutions at the same time).

b. The dates of service for a practitioner claim should not overlap with the dates of service for another claim from the same practitioner.
(Note that the above automatically detects exact duplicates.)

c. Claims with a diagnosis and procedure which indicate an emergency should not occur within one day of a similar claim from the same provider.

Many other conflicts between claims are possible. However, the programs of the various states must serve as the guidelines for conflicting claim detection. Some representative examples would be:

a. Surgeon billing for hospital visits in addition to his surgery fee.

b. Physician billing for several different procedures which are inconsistent on the same day.

c. Hospital patient's attending physician billing for multiple visits on the same day.

This processing step must be able to detect discrepancies, not only between current claims and claims already paid, but between two claims, both of which are currently being processed.

In some instances, it is possible for line items on a single claim to conflict with each other. This condition must be detected also.

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C3.6 | Data Processing | Those claims which were flagged as "over age" during the normal duplicate/conflict processing (Step C3.5) are checked against the Master Skeletal History File during this step. The master history file contains records of all claims less than two years old. Because of the volume of historical claims involved, this step occurs weekly or bi-weekly. The Claims Processing Suspense File (which contains all those claims flagged as too old for the normal duplicate/conflict edit) is passed against the master history file. The same edits used in the normal duplicate checking routine are applied here. Those suspended claims which do not duplicate or conflict with the master history are flagged so that on their next processing by the daily duplicate/conflict routine (Step C3.5) they will be approved for payment. |

## DISTRIBUTION MODULE

### FUNCTIONS

The Distribution Module accepts the Claims Processing Transaction File from the Adjudication Module. At this point, all transactions processed by the Claims Processing Subsystem have been approved, disallowed, or suspended for further processing. The Distribution Module performs the following major functions:

a. All claim transactions which are to be suspended are documented by means of a Transaction Exception Listing.

b. All claims flagged for investigative follow-up because of third-party discrepancies are listed.

c. All recipients for whom claims were processed which indicated the recipient's death are listed for follow-up by recipient eligibility personnel.

d. Registers which serve as audit trails for the process cycle are generated.

e. Responses for the queries submitted to the subsystem are generated.

f. A summary of processing through the subsystem is produced.

g. Claim transactions approved or disallowed are placed in the Adjudicated Claims File.

h. All unadjudicated transactions are suspended.

i. Reimbursement amounts inserted in claim transactions by the Adjudication Module are used to calculate payment amounts for all approved claim transactions.

### OUTPUTS

This module is responsible for virtually all of the outputs of the Claims Processing Subsystem with the exception of those generated by the Payment Module. The Distribution Module produces the following major outputs:

a. Transaction Exception Listing -- all nonadjudicated claim transactions are listed indicating the transaction

identification and the reason for the exception.

b. Third-party Liability Follow-up Report -- this report lists all claims which were allowed, but indicate a need for investigation because of possible third-party discrepancies.

c. Deceased Recipient Listing -- any recipient for whom a claim is filed which indicates the recipient's death and whose eligibility record does not indicate death is listed for investigation.

d. Transaction Register -- a detailed listing of all claim transactions passing through the subsystem is produced.

e. Credit and Adjustment Control Listing -- as a supplement to the Transaction Register, all credits and adjustments are summarized in further detail.

f. Internal Query Responses -- the responses to queries submitted by claims processing agency personnel are printed.

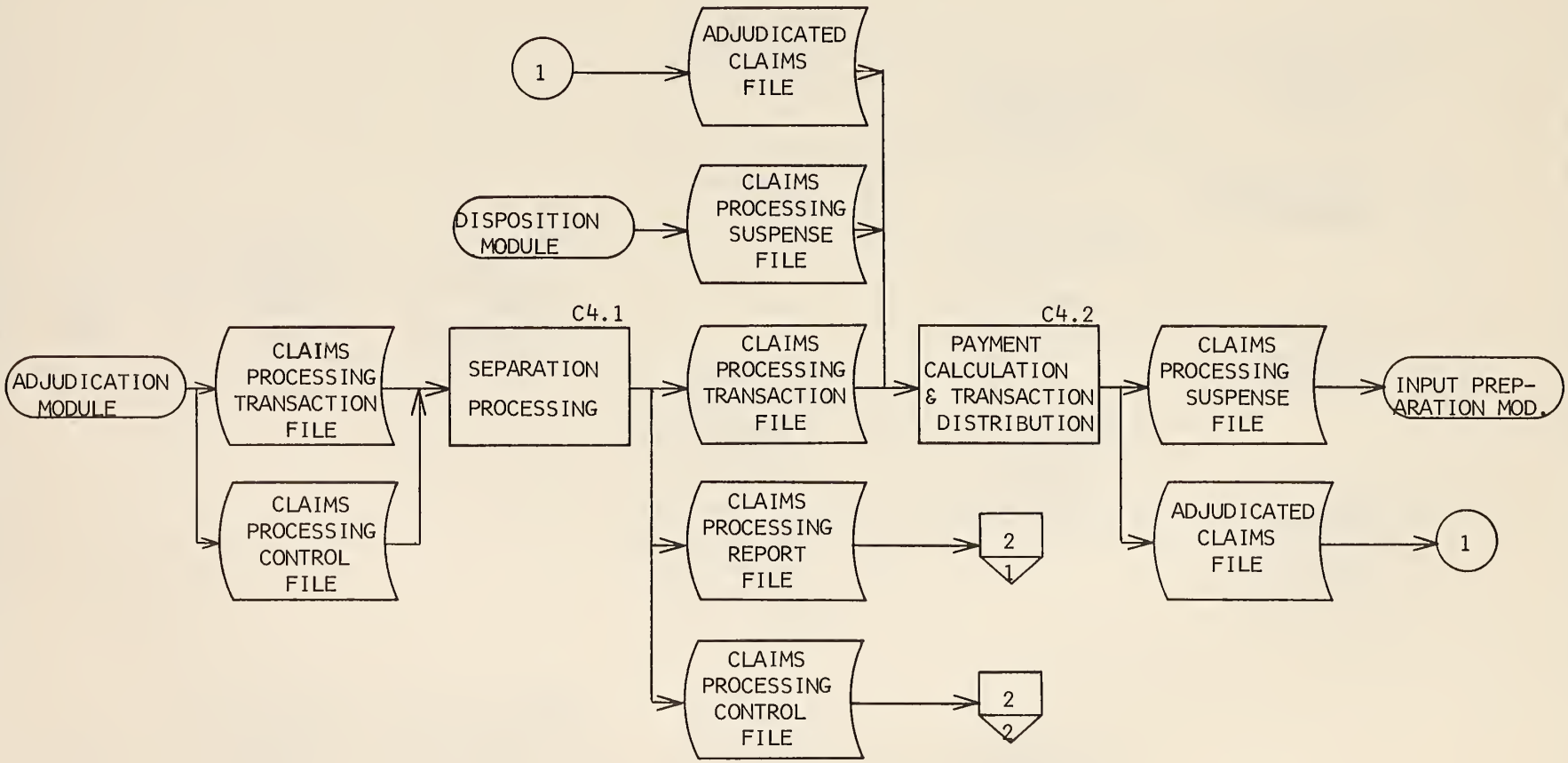
g. Provider Query Responses -- all providers submitting a query are furnished with a recipient's eligibility and benefit data.

h. Daily Processing Log -- a report which summarizes all daily processing, by record counts and dollar totals, is produced.

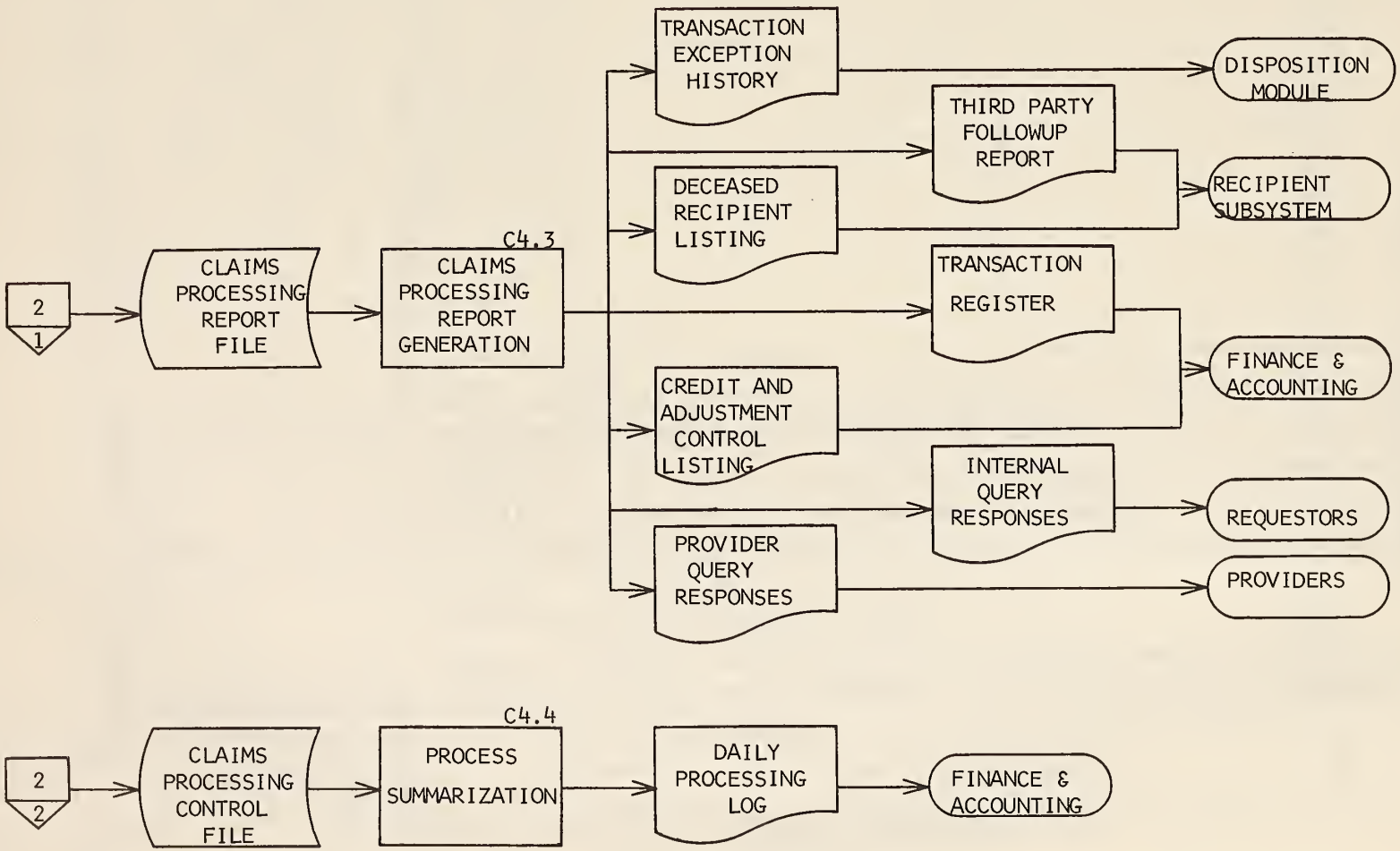
i. Claims Processing Suspense File -- all claim transactions which require further processing to adjudicate them are assembled for further processing.

j. Adjudicated Claims File -- all claims, credits, and adjustments approved for payment or disallowed are placed in this file.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - DISTRIBUTION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - DISTRIBUTION MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM | | Claims Processing |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| C4.1 | Date Processing | The Claims Processing Transaction File is passed and information for report generation is extracted and used to create a report file. The transaction file remains intact. |
| C4.2 | Data Processing | The Claims Processing Transaction File is separated into two files. A file of adjudicated transactions is combined with those adjudicated previously. A file of suspensed transactions is combined with the existing suspense file creating the current Claims Processing Suspense File. A payment amount is calculated for all adjudicated claim transactions (see Exhibit IV-10 following this page for payment logic). |

## PAYMENT CALCULATION LOGIC

The payment amount is determined to be the least amount indicated for a provider in this table:

| Type of Provider \ Payment Method | Provider's Submitted Charge | Provider's Usual & Cust. Charge | Area Prevailing Charge | Reasonable Cost | Per Diem or Per Service Rate | Cost Plus Prof. Fee | Percent of Submitted Charges | Fee Schedule | Medicare Usual and Cust. Charge | Medicare Area Prevailing Charge | Negotiated Fees |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physician & Practitioner | X | X | | | | | | X | X | X | |
| Hospital, Inpatient | | | | X | X | | X | | | | X |
| Hospital, Outpatient | | | | X | X | | X | | | | X |
| Skilled Nursing Facility & ICF | | | | X | X | | X | | X | X | X |
| Pharmacy | X | | | | | X | | | | | |
| Home Health Agency | X | | | X | X | | X | | | | X |
| Independent Laboratory & X-ray | X | X | X | | | | X | X | X | | |
| Medical Supplier | X | | | | | X | X | X | X | X | |
| Medical Screening | X | X | X | | X | | X | X | | | X |
| Clinic | X | X | X | X | X | | X | X | X | X | X |
| Other | X | X | X | X | | | X | X | X | X | X |

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | PROCESS STEP DEFINITION |
|---|---|

SUBSYSTEM Claims Processing

| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
|---|---|---|
| C4.3 | Data Processing | Utilizing the report file generated during Step C4.1, all reports produced by this module, except the Daily Processing Log, are printed. |
| C4.4 | Data Processing | The Claims Processing Control File is used to produce the Daily Processing Log, a complete summary of the Claims Processing Subsystem cycle. |

## PAYMENT MODULE

### FUNCTIONS

On a periodic basis determined by individual State policy, the Adjudicated Claims File, which contains all claim transactions approved for payment or disallowed, is used to render payment or notification of disallowance to providers. Provider gross adjustments representing cost settlements, cash advances, and recovery of Medicaid funds, are handled within this module also. The Payment Module performs the following major functions:

a. Creation of historical records used for input to the Surveillance and Utilization Review and the Management and Administrative Reporting Subsystems.

b. Preparation of payment instruments and their supporting documentation.

c. Generation of explanation of medical benefits furnished.

### OUTPUTS

The Payment Module produces the following major outputs:

a. Claims History File -- a file of adjudicated claim transactions used as input to the Surveillance and Utilization Review Subsystem and the Management and Administrative Reporting Subsystem.

b. Remittance Statements -- documents supporting all payments and disallowance for a provider.

c. Checks (drafts, warrants) -- depending on State policy, a vehicle for reimbursing the provider.

d. Payment Summary -- a summary of all payments is created.

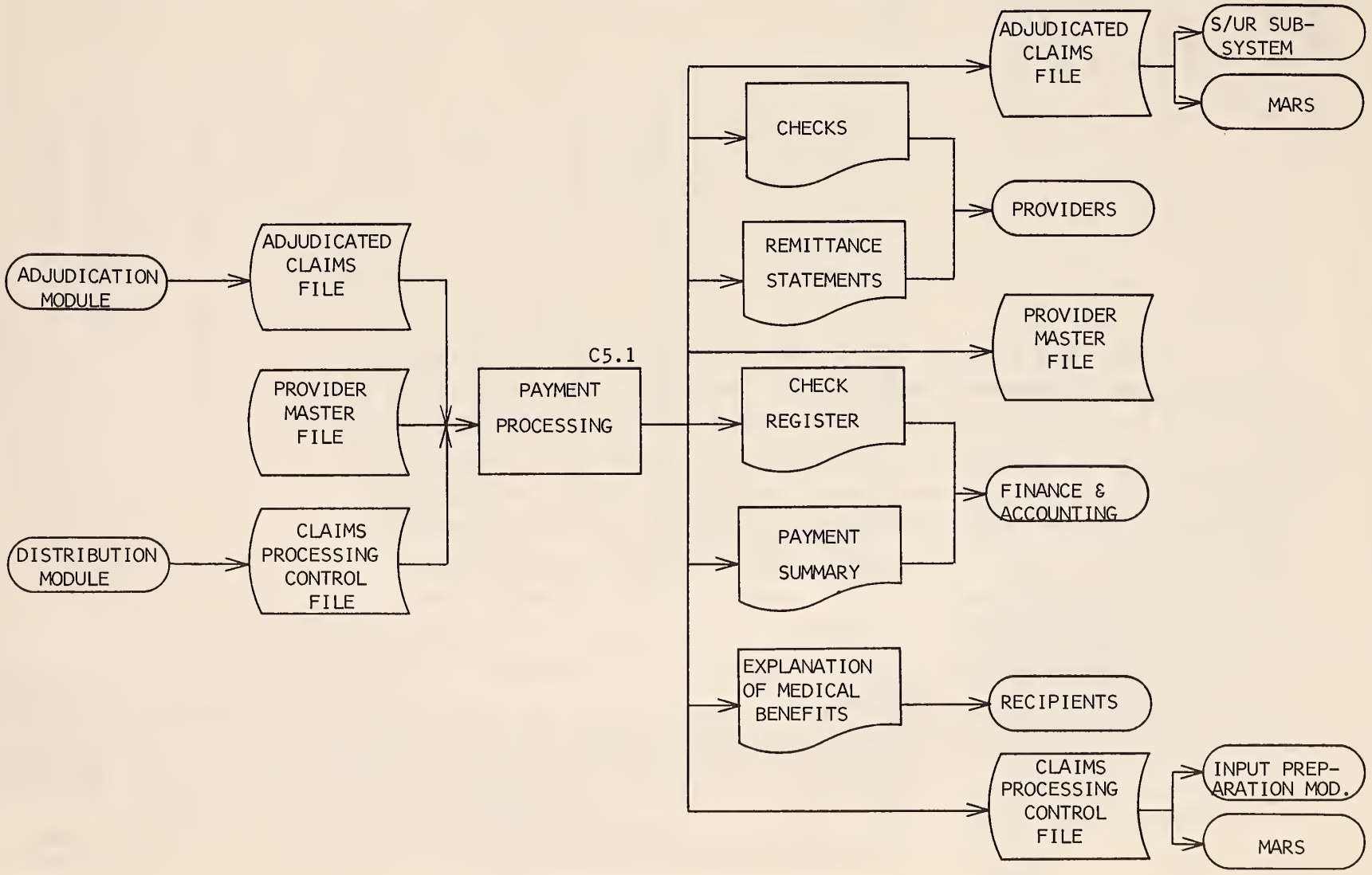
e. Check Register -- a record of all checks (drafts, warrants) is produced.

f. Explanation of Medical Benefits -- a detailed record of services paid for is generated for all recipients.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOWCHART

SUBSYSTEM CLAIMS PROCESSING SUBSYSTEM - PAYMENT MODULE



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM | Claims Processing | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| C5.1 | Data Processing | The Adjudicated Claims File is used to compute payment amounts and credit balances for providers. The Provider Master File serves as a name/address file for checks (warrants, drafts) and remittance statements and is updated with current credit balance information. Checks (warrants, drafts) and Remittance Statements are produced for providers. A summary of the payment processing and a Check (warrant, draft) Register is generated. Explanations of Medical Benefits are printed for all recipients. The Claims Processing Control File is updated to reflect the results of the payment processing. |

## D. SUBSYSTEM OUTPUTS

The Claims Processing Subsystem produces the outputs listed below. The purpose, distribution, and sequence of each output are presented on an Output Definition Sheet. Whenever practical this sheet is followed by a sample report layout that describes the general format and content of the report. The data displayed on the reports are entirely fictitious with little regard given to reasonableness or cross footing of the numbers. The purpose of the sample data is solely one of assistance to the reader in more readily gaining an understanding of the report. The three digit numbers that appear on each report are data element numbers identifying the data elements contained within that report. Definitions for all data elements, and where applicable, a recommended coding structure can be found in the Appendix.


| Output Number | Output Name | Page Number |
|---|---|---|
| CP-0-Ø1 | Input Control Listing | IV-86 |
| CP-0-Ø2 | Disposition Processing Control Listing | IV-92 |
| CP-0-Ø3 | Transaction Exception Listing | IV-94 |
| CP-0-Ø4 | Third Party Liability Followup Report | IV-96 |
| CP-0-Ø5 | Deceased Recipient Listing | IV-98 |
| CP-0-Ø6 | Transaction Register | IV-100 |
| CP-0-Ø7 | Credit and Adjustment Control Listing | IV-102 |
| CP-0-Ø8 | Internal Query Response | IV-104 |
| CP-0-Ø9 | Provider Query Response | IV-106 |
| CP-0-1Ø | Daily Processing Log | IV-108 |
| CP-0-11 | Provider Checks | IV-110 |
| CP-0-12 | Remittance Statements | IV-112 |
| CP-0-13 | Check Register | IV-118 |
| CP-0-14 | Payment Summary | IV-120 |
| CP-0-15 | Explanation of Medical Benefits | IV-122 |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Input Control Listing | CP-O-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Input Preparation Module<br>Process Step C1.15 | Daily |
| | **MEDIA**<br>Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Data Preparation Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Sequence of input | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Provides a summary of all subsystem input.
2) Furnishes data which has probably caused error in batch. (Details error detected which caused rejection of a batch).

**REMARKS**

# T I T I E X I X I N P U T C O N T R O L L I S T I N G

## INPUT SUMMARY

| BATCH NO. | NO. OF TRANSACTIONS IN BATCH | BATCH TYPE | ERROR MESSAGE |
|---|---|---|---|
| 20014001 | 26 | REGULAR | |
| 20014002 | 32 | REGULAR | DOES NOT BALANCE |
| 20018001 | 25 | REGULAR | |
| 20010001 | 30 | REGULAR | |
| 13638215 | 27 | CORRECTED BATCH | |
| 2001L950 | 40 | DIRECT FROM PROVIDER | |
| 20015100 | 25 | MEDICARE CROSSOVER | |
| 309 | | | |
| TOTAL INPUT TRANSACTIONS | 205 | | |
| | 308 | | |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-01

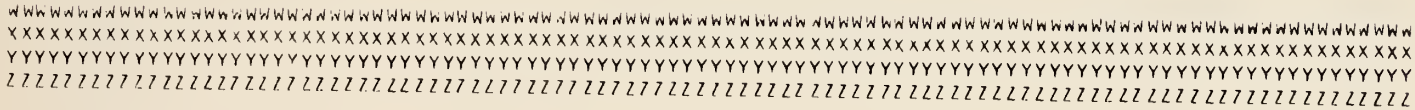
T I T L E  X I X  I N P U T  C O N T R O L  L I S T I N G

ERROR BATCH DETAILS

ERROR MESSAGES

308 INPUT RECORD IMAGE

BATCH NO. 2001W003



INVALID RECORD CODE



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-01

# T I T L E  X I X  I N P U T  C O N T R O L  L I S T I N G

## INPUT TOTALS

CATEGORY OF SERVICE — TRANSACTION TOTALS BY TYPE

| 301 | CLAIMS | CREDITS AND ADJUSTMENTS | REQUESTS FOR PRIOR AUTHORIZATIONS | DIRECT INPUT FROM PROVIDERS | MEDICARE CROSSOVERS | TOTAL |
|---|---|---|---|---|---|---|
| INPATIENT | 586 | 23 | 0 | 102 | 158 | 869 |
| OUTPATIENT | 1027 | 6 | 0 | 350 | 419 | 1802 |
| SKILLED NURSING HOME | 58 | 0 | 32 | 0 | 56 | 146 |
| HOME HEALTH AGENCY | 21 | 0 | 0 | 0 | 23 | 44 |
| PERIODIC SCREENING | 76 | 0 | 0 | 0 | 0 | 76 |
| PHYSICIAN | 1783 | 15 | 17 | 0 | 602 | 2417 |
| DENTAL | 17 | 1 | 18 | 0 | 0 | 36 |
| OTHER PRACTITIONERS | 3 | 0 | 0 | 0 | 0 | 3 |
| PHARMACY | 1587 | 35 | 0 | 257 | 0 | 1879 |
| TOTAL | 5158 | 80 | 67 | 709 | 1258 | 7272 |

TOTAL BATCHES 287

BATCHES REJECTED 17



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-01

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Disposition Processing Control Listing | CP-O-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Disposition Module<br>Process Step C2.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Transaction Control Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Provides a record of all corrective actions applied to exception transactions.
2) Identifies corrective actions which are in error.

**REMARKS**

# D I S P O S I T I O N  P R O C E S S I N G  C O N T R O L  L I S T

| TRANSACTION CONTROL NO. | ACTION TAKEN | ERROR MESSAGE |
|---|---|---|
| 1361A00721 | DELETED FROM SUSPENSE FILE | |
| 1362A05302 | ERROR CODE 216 OVERRIDDEN | |
| 1363C12718 | FIELD NO. 68 CHANGED FROM 112672 TO 112671 | |
| 1363E00909 | DISALLOWED | |
| 1364M10003 | NONE | NO SUSPENSE RECORD WITH THIS TRANSACTION CONTROL NO. |
| 1364T00742 | NONE | CAN NOT OVERRIDE ERROR CODE 063 |

300 337 338



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-02

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Claims Transaction Exception Listing | CP-0-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Transaction Control Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Identifies transactions which were not adjudicated due to exception conditions.

2) Describes the nature of the error or exception.

3) Provides a work sheet for preparing corrective actions.

**REMARKS**

# TRANSACTION EXCEPTION LISTING

| CORRECTIVE ACTION CODE | TRANSACTION CONTROL NO. | NEW FIELD CONTENTS OR ERROR OVERRIDE | ERROR CODE | FIELD NO. | CONTENTS |
|---|---|---|---|---|---|
| | 1351A02711 | | 281 | 073 | 102772 |
| | 1352B07306 | | 015 | 218 | 10.00 |
| | | | | 219 | 50.00 |
| | | | | 230 | 15.00 |
| | 1360J00307 | | 104 | 008 | 14728217963 |
| | | | 213 | 100 | A |
| | 300 | | 372 | 382 | |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-03

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Third Party Followup Report | CP-O-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Recipient Subsystem |
| 2. | Claims Processing Unit |
| 3. | Surveillance and Utilization Review Subsystem |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Recipient I.D. Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Identifies recipients whose claim form did not indicate third party liability, however, the diagnosis and/or procedures have characteristics which indicate a need for investigation of possible third party involvement.
2) Identifies recipients whose claims indicate third party payments, but whose eligibility records indicate no third party resources.
3) Medicare coverage evident from claim but not eligibility file.

**REMARKS**

RUN DATE 01/01/72



# THIRD PARTY FOLLOWUP REPORT

| RECIPIENT ID NO. | TRANSACTION CONTROL NO. | REASON FOR FOLLOWUP |
|---|---|---|
| 1234567890 | 1364A00701 | CLAIM INDICATES THIRD PARTY PAYMENT--ELIGIBILITY FILE INDICATES NO OTHER RESOURCES |
| 2345678901 | 1363B00307 | DIAGNOSIS CODE INDICATES POSSIBILITY OF WORKMENS COMPENSATION LIABILITY |
| 3456789012 | 2001Q01713 | DIAGNOSIS CODE INDICATES POSSIBILITY OF ACCIDENT |
| 4567890123 | 1364M02804 | CROSSOVER CLAIM FOR RECIPIENT - ELIGIBILITY FILE INDICATES NO MEDICARE COVERAGE |

101 300 385



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-04

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Deceased Recipient Listing | CP-0-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Recipient Subsystem |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Recipient I. D. Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Identifies recipients for whom claims have been received indicating the recipient's death but whose eligibility record indicates they are still eligible for services.

**REMARKS**

RUN DATE 01/01/71



# D E C E A S E D  R E C I P I E N T  L I S T I N G

| RECIPIENT ID NO. | TRANSACTION CONTROL NO. | INDICATED DATE OF DEATH |
|---|---|---|
| 7654321098 | 1364E07203 | 11/15/71 |
| 8765432109 | 2001A01614 | 11/07/71 |
| 9876543210 | 1363B01301 | 12/16/71 |
| 101 | 300 | 313 |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-05

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Transaction Register | CP-O-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Finance and Accounting |
| 2. | Claims Processing Unit |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Transaction Control Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Provides a detailed list of all claim transactions processed by the subsystem.

**REMARKS**

If transaction volume is exceptionally large, daily printing of this output may be undesirable. In such cases, it would be written on tape and printed only if necessary.

# TRANSACTION REGISTER

| TRANSACTION CONTROL NO. | *--RECIPIENT--* ID NO. | NAME | PROVIDER NO. | DATES OF SERVICE | DIAG CODE | DRUG CODE OR PROCEDURE | UNITS OF SERVICE | PROVIDER CHARGES | PAYMENT AMOUNT OR ERROR CODES |
|---|---|---|---|---|---|---|---|---|---|
| 2001K01701 | 1234567890 | JONES | 1234567 | 12/07/71--12/09/71 | 2640 | 60270 | 2 | 418.27 | 242.00 |
| 2001K01702 | 6655443322 | SMITH | 6352410 | 12/03/71--12/10/71 | 4183 | 12340 | 7 | 1264.16 | 609.00 |
| 2001L0170201 | 2468013579 | DOE | 4182736 | 12/16/71--12/16/71 | 7140 | OTC-12345 | 1 | 4.60 | 841 607 |
| 300 | 101 | 103 | 201 | 312 | 313 | 306 501 | 327 | 321 | 349 372 |

IV-101

REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-06

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Credit and Adjustment Control Summary | CP-0-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Finance and Accounting |
| 2. | Claims Processing Unit |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Transaction Control Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Supplements the Transaction Register by providing extra detail for credits and adjustments processed.

**REMARKS**

RUN DATE 01/01/72



# CREDIT AND ADJUSTMENT CONTROL LISTING

| TRANSACTION CONTROL NO. | PROVIDER NO. | ORIGINAL TRANSACTION NO. | ORIGINAL PAYMENT AMOUNT | NEW PAYMENT AMOUNT | NET ADJUSTMENT |
|---|---|---|---|---|---|
| 2001N90001 | 1234567 | 1351G00103 | 207.18 | 0.00 | 207.18CR |
| 2001N90002 | 2345678 | 1352L01608 | 342.20 | 1342.20 | 1000.00 |
| 2001N90003 | 3456789 | 1321Q02901 | 16.00 | 8.00 | 8.00CR |
| | | TOTALS | 565.38 | 1350.20 | 784.82 |
| 300 | 201 | 300 | 349 | 349 | 334 335 |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-07

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Internal Query Responses | CP-O-Ø8 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Individual making query |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Requestor of query response | 4. | |
| 2. | Recipient I.D. Number | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Furnishes all available data for a given recipient. (Within appropriate personal data disclosure constraints)

**REMARKS**

Optionally, a listing of the recipient's more recent claims can be obtained.

# INTERNAL QUERY RESPONSE

REQUESTED BY - AB 383

## BASIC DATA

| | | |
|---|---|---|
| RECIPIENT NO. | 1234567890 | 101 |
| RECIPIENT NAME | A B RECIPIENT | 103 |
| SEX | M | 107 |
| RACE | 2 | 106 |
| BIRTHDATE | 03/21/90 | 105 |
| HIB NO. | 418261728A | |
| THIRD PARTY LIABILITY | 04 | |
| MONEY PAYMENT STATUS | Y | |

## ELIGIBILITY DATA

| BEGIN DATE | END DATE | COUNTY | AID CATEGORY |
|---|---|---|---|
| 01/01/68 | 07/31/69 | 27 | 01 |
| 08/01/69 | NOW OPEN | 62 | 01 |
| 110 | 111 | 108 | 109 |

## BENEFIT DATA

| | |
|---|---|
| INPATIENT DAYS REMAINING | 30 |
| OUTPATIENT VISITS REMAINING | 26 |
| HOME HEALTH AGENCY VISITS REMAINING | 41 |

IV-105

## CLAIM HISTORY

| TRANSACTION CONTROL NO. | PROVIDER NO. | DIAG-NOSIS | PROC OR DRUG | DATES OF SERVICE | CHARGE AMOUNT | PAYMENT AMOUNT | STATUS | UNITS OF SERVICE |
|---|---|---|---|---|---|---|---|---|
| 1068M01604 | 2468123 | 3180 | 90000 | 01/06/71--01/06/71 | 10.00 | 8.00 | B | 01 |
| 1069L0030703 | 5678901 | 3180 | OTC-1234 | 01/06/71--01/06/71 | 1.80 | 1.80 | B | 01 |
| 300 | 201 | 306 | 500<br>501 | 312 313 | 321 | 349 | 316 | 327 |

REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-08

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Provider Query Responses | CP-0-Ø9 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.3 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Provider making query |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Provider Number | 4. | |
| 2. | Recipient ID Number | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Furnishes a response to a provider's request for recipient data. (Within appropriate personal data disclosure constraints)

**REMARKS**

# PROVIDER QUERY RESPONSE

202 ABC GENERAL HOSPITAL 6543210 201
1234 ELM ST.
203 ANYTOWN, USA
12345

RECIPIENT NAME A B RECIPIENT 103
RECIPIENT NO. 1234567890
PATIENT RECORD NO. 162534 101

DATE OF QUERY 12/30/71

RECIPIENT ELIGIBLE ON DATE OF QUERY

OTHER RESOURCES - PRIVATE INSURANCE
PART B MEDICARE

INPATIENT DAYS REMAINING 22
OUTPATIENT VISITS REMAINING 37



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-09

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Daily Processing Log | CP-0-1Ø |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Distribution Module<br>Process Step C4.4 | Daily |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Process Control Supervisor |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Processing Steps | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Provides a summary of subsystem processing.

2) Ensures that all processing totals balance properly.

**REMARKS**

# DAILY PROCESSING LOG

| | TRANSACTIONS | CHARGES | |
|---|---|---|---|
| A. INPUT CLAIMS | 2518 | $ 132,764.83 | 354 |
| B. INPUT CREDITS AND ADJUSTMENTS | 53 | 1,418.68CR | 355 |
| C. INPUT APPROVED PRIOR AUTHORIZATIONS | 15 | | 356 |
| D. INPUT QUERIES | 207 | | 357 |
| E. NEW INPUT TO SYSTEM (A + B + C + D) | * 2793 | * 131,346.15 | |
| F. SUSPENSE CLAIMS | 506 | 27,418.63 | 358 |
| G. SUSPENSE CREDITS AND ADJUSTMENTS | 16 | 962.08CR | 359 |
| H. SUSPENSE APPROVED PRIOR AUTHORIZATIONS | 68 | | 360 |
| I. PREVIOUSLY ADJUDICATED CLAIMS | 4270 | 249,761.14 | 361 |
| J. PREVIOUSLY ADJUDICATED CREDITS AND ADJUSTMENTS | 241 | 9,612.64CR | 362 |
| K. TOTAL SYSTEM INPUT (E + F + G + H + I + J) | ** 7894 | ** 357,951.20 | |
| L. SUSPENSE TRANSACTIONS DELETED | 52 | 1,416.20 | 363 |
| M. CORRECTIONS TO CHARGE AMOUNTS | | 27.00CR | 364 |
| N. PRIOR AUTHORIZATIONS MATCHED AND PURGED | 22 | | 365 |
| O. ADJUSTED SYSTEM TOTAL (K - L + M - N) | *** 7820 | *** 356,508.00 | |
| P. ADJUDICATED CLAIM OUTPUT | 6593 | 327,406.82 | 366 |
| Q. ADJUDICATED CREDIT AND ADJUSTMENT OUTPUT | 286 | 10,268.33CR | 367 |
| R. SUSPENSE CLAIMS | 649 | 41,094.58 | 368 |
| S. SUSPENSE CREDITS AND ADJUSTMENTS | 24 | 1,725.07CR | 369 |
| T. SUSPENSE APPROVED PRIOR AUTHORIZATIONS | 61 | | 370 |
| U. QUERIES PRINTED | 207 | | 371 |
| V. TOTAL SYSTEM OUTPUT (P + Q + R + S + T + U) | *** 7820 | *** 356,508.00 | |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-10

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Provider Checks | CP-0-11 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Payment Module<br>Process Step C5.1 | Each payment cycle |
| | **MEDIA** |
| | Check or draft |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Provider |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Provider Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Reimburses provider for services rendered.

**REMARKS**

SINGLE STATE AGENCY FOR MEDICAID

CHECK NO. M-00673

01/01/72

PAY TO THE ORDER OF

202 XYZ NURSING HOME
123 RESTFUL ST.
203 HAPPY ACRES, USA
98765

$**2418AND62/100 347

THIS REIMBURSEMENT IS FOR SERVICES RENDERED UNDER
TITLE XIX OF THE SOCIAL SECURITY ACT.



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-11

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Remittance Statements | CP-0-12 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Payment Module<br>Process Step C5.1 | Each payment cycle |
| | **MEDIA** |
| | Preprinted form |

**DISTRIBUTION**

1. Provider
2. Claims Processing Unit
3. Finance and Accounting
4.
5.

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Provider Number | 4. | Dates of Service |
| 2. | Category of Service | 5. | |
| 3. | Recipient Name | 6. | |

**PURPOSE OF OUTPUT**

1) Furnishes the provider a detailed listing of all claims, credits, and adjustments comprising his payment.

2) Informs the provider of his claims, credits, and adjustments which have been disallowed.

**REMARKS**

# T I T L E  X I X  R E M I T T A N C E  S T A T E M E N T

202

ABC GENERAL HOSPITAL
456 OAK ST.
OAKVILLE, USA 12345 203

327

PAID CLAIMS--INPATIENT SERVICES

| 103 NAME | 101 ID NO. | 320 PATIENT NO. | 312 313 DATES OF SERVICE | 321 UNITS OF SERVICE | CHARGE AMOUNT | 349 PAYMENT AMOUNT | 300 TRANSACTION CONTROL NO. | REMARKS |
|---|---|---|---|---|---|---|---|---|
| A B RECIPIENT | 1234567890 | B674 | 12/26/71--12/27/71 | 2 | 221.72 | 126.00 | 1364Q01603 | |
| B C RECIPINTE | 4567890123 | H418 | 12/03/71--12/15/71 | 13 | 4671.89 | 819.00 | 1352Q41819 | |
| | | | TOTALS | 15 | 4893.61 | 945.00 | 1361Q06801 | |

DISALLOWED CLAIMS--INPATIENT SERVICES

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| X Y CLIENT | 2222222222 | C028 | 12/11/71--12/12/71 | 1 | 105.18 | 0.00 | 1360Q30016 | SERVICE NOT COVERED |

IN PROCESS CLAIMS--INPATIENT SERVICES

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| P Q RECIP | 9876543210 | L914 | 12/26/71--12/30/71 | 4 | 403.27 | 0.00 | 1348Q00104 | AWAITING ELIGIBILITY INFO |

PAID CLAIMS--OUTPATIENT SERVICES

| *-------RECIPIENT-------* NAME | ID NO. | PATIENT NO. | DATES OF SERVICE | UNITS OF SERVICE | CHARGE AMOUNT | PAYMENT AMOUNT | TRANSACTION CONTROL NO. | REMARKS |
|---|---|---|---|---|---|---|---|---|
| L B SMITH | 6789098671 | M048 | 12/13/71--12/13/71 | 1 | 10.00 | 8.00 | 1361S06203 | |
| | | | TOTALS | 1 | 10.00 | 8.00 | | |

DISALLOWED CLAIMS--OUTPATIENT SERVICES

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| J R DOE | 1357902468 | M613 | 03/21/71--03/22/71 | 2 | 20.00 | 0.00 | 1360S04116 | DOES NOT MEET FILING LIMIT |

PAID CLAIMS--INPATIENT DEDUCTIBLES AND COINSURANCE

| *-------RECIPIENT-------* NAME | ID NO. | PATIENT NO. | DATES OF SERVICE | DEDUCTIBLES CASH | BLOOD | COIN-SURANCE | PAYMENT AMOUNT | TRANSACTION CONTROL NO. | REMARKS |
|---|---|---|---|---|---|---|---|---|---|
| J Q JONES | 66655544432 | B850 | 11/16/71--11/23/71 | 56.00 | 25.00 | 11.00 | 92.00 | 1362P00213 | |
| | | | TOTALS | 56.00 | 25.00 | 11.00 | 92.00 | | |
| | | | | 330 | 331 | 332 | | | |

TOTAL PAYMENT AMOUNT 1045.00
CREDIT BALANCE AMOUNT 200.00CR

NET CHECK AMOUNT 845.00 347

REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-12

# TITLE XIX REMITTANCE STATEMENT

202

A T SMITH, MD
BOX 999
ANYCITY, USA 98765

203

| 103 NAME | 101 ID NO. | DATES OF SERVICE 312 | 313 | 500 PROCEDURE | 327 UNITS OF SERVICE | 322 CHARGE AMOUNT | 349 PAYMENT AMOUNT | 300 TRANSACTION CONTROL NO. | REMARKS |
|---|---|---|---|---|---|---|---|---|---|
| J R DOE | 2468097531 | 12/08/71 | 12/10/71 | 90200 | 03 | 16.00 | 12.00 | 1359S06801 | CHARGE REDUCED TO REASONABLE |
| | | 12/16/71 | 12/16/71 | 84320 | 01 | 3.00 | 0.00 | 02 | SERVICE NOT COVERED |
| | | 12/20/71 | 12/21/71 | 90040 | 02 | 10.00 | 10.00 | 03 | |
| | | | | TOTALS | 06 | 321 29.00 | 22.00 | | |
| A B SMITH | 9876543210 | 12/09/71 | 12/09/71 | 0138 | 01 | 175.00 | 175.00 | 1362T02101 | |
| | | | | TOTALS | 01 | 175.00 | 175.00 | | |
| | | | | TOTAL PAYMENT AMOUNT | | | 197.00 | | |
| | | | | CREDIT BALANCE AMOUNT | | | 0.00 | | |
| | | | | NET CHECK AMOUNT | | | 197.00 | 347 | |

IV-115

REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-12

01/01/72

# TITLE XIX REMITTANCE STATEMENT

PQR PHARMACY
201 EAST ST.
WESTVILLE, USA 64208

| *-------RECIPIENT-------* NAME | ID NO. | 386 RX NO. | 315 RE-FILL | RX DATE | 501 DRUG CODE | 323 CHARGE AMOUNT | PAYMENT AMOUNT | TRANSACTION CONTROL NO. | REMARKS |
|---|---|---|---|---|---|---|---|---|---|
| A B CLIENT | 1234567890 | 2618 | 1 | 12/18/71 | OTC-98763 | 6.50 | 6.00 | 1361T0162301 | EXCEEDED ALLOWABLE CHARGE |
| B C DRIFTER | 2345678901 | 2623 | 0 | 12/18/71 | 431-16000 | 2.00 | 2.00 | 02 | |
| C D ELWOOD | 3456789012 | 2691 | 0 | 12/18/71 | 608-15239 | 3.50 | 0.00 | 03 | DUPLICATE CLAIM |
| D E FINKLE | 4567890123 | 2708 | 1 | 12/19/71 | 123-45673 | 4.80 | 4.80 | 04 | NO PROFESSIONAL FEE ALLOWED |
| E F GARGOYLE | 5678901234 | 2716 | 0 | 12/19/71 | GEN-67803 | 10.00 | 0.00 | 05 | IN PROCESS |
| | | | | TOTALS | | 26.80 | 12.80 | | |
| | | | | PROFESSIONAL FEES | | | 4.00 | 381 | |
| | | | | TOTAL PAYMENT AMOUNT | | | 16.80 | | |
| | | | | CREDIT BALANCE AMOUNT | | | 47.62CR | | |
| | | | | NET CHECK AMOUNT | | | 30.82CR | *** CREDIT BALANCE--NO CHECK *** | |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-12

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Check Register | CP-0-13 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Payment Module<br>Process Step C5.1 | Each Payment Cycle |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Finance and Accounting |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Check Number | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Provides a detail listing of all checks written.

2) Provides an aged listing of all provider credit balances.

**REMARKS**

RUN DATE 01/01/71



# T I T L E  X I X  C H E C K  R E G I S T E R

| PROVIDER NO. | PROVIDER NAME | CHECK NO. | CHECK AMOUNT | CREDIT BALANCE AMOUNT | AGE (IN DAYS) |
|---|---|---|---|---|---|
| | | | 347 | | |
| 1234567 | ABC HOSPITAL | M-00641 | 264.87 | | |
| 1234570 | XYZ HOSPITAL | M-00642 | 10,721.13 | | |
| 1234587 | PQR NURSING HOME | | *ZERO* | 189.16CR | 60 |
| 1234602 | LMN PHARMACY | | *ZERO* | 1.29CR | 30 |
| 1234613 | DR. J R JONES | M-00643 | 640.00 | | |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-13

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Payment Summary | CP-0-14 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Payment Module<br>Process Step C5.1 | Each Payment Cycle |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Finance and Accounting |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Category of Service | 4. | |
| 2. | Aid Category | 5. | |
| 3. | Fiscal Year | 6. | |

**PURPOSE OF OUTPUT**

1) Summarizes the payment processing giving total payments by category of service and fiscal year of service.

**REMARKS**

# TITLE XIX PAYMENT SUMMARY

TOTAL INPUT

| TRANSACTIONS | PAYMENT AMOUNT |
|---|---|
| 127,918 | 3,089,430.00 |

OUTPUT PAYMENTS

| CATEGORY OF SERVICE | CURRENT FISCAL YEAR TRANSACTIONS | CURRENT FISCAL YEAR PAYMENT AMOUNT | PREVIOUS FISCAL YEAR TRANSACTIONS | PREVIOUS FISCAL YEAR PAYMENT AMOUNT |
|---|---|---|---|---|
| INPATIENT | 4,803 | 982,000.00 | 16 | 1,600.00 |
| OUTPATIENT | 10,006 | 123,000.00 | 101 | 1,200.00 |
| SKILLED NURSING HOME | 8,064 | 1,218,600.00 | 10 | 3,000.00 |
| HOME HEALTH AGENCY | 896 | 40,000.00 | 6 | 250.00 |
| PHYSICIAN | 54,232 | 542,000.00 | 268 | 2,950.00 |
| DENTAL | 984 | 22,000.00 | 32 | 700.00 |
| OTHER PRACTITIONER | 57 | 1,400.00 | 0 | .00 |
| PERIODIC SCREENING | 943 | 9,430.00 | 0 | .00 |
| PHARMACY | 47,042 | 140,000.00 | 458 | 1,300.00 |
| TOTAL | 127,027 | 3,078,430.00 | 891 | 11,000.00 |
| 301 | | 349 | | 349 |



REPORT FORMAT SAMPLE

OUTPUT NO. CP-0-14

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Explanation of Medical Benefits | CP-O-15 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Payment Module<br>Process Step C5.1 | Monthly or Each Payment Cycle |
| | **MEDIA** |
| | Preprinted Form |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Recipient |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Recipient I.D. Number | 4. | |
| 2. | Dates of Service | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

1) Informs the recipient of provider billings for services that were rendered to or for the recipient.

**REMARKS**

Optional copy to Social Services Department

01/01/72

TO: A B RECIPIENT 103 1234567890 101
987 14 ST.
ANYTOWN, USA 12345

FROM: MEDICAID SINGLE STATE AGENCY

PAYMENT FOR THE FOLLOWING SERVICES WAS MADE ON YOUR BEHALF BY YOUR MEDICAID AGENCY. IF YOU DID NOT RECEIVE SUCH SERVICES OR THE SERVICE DESCRIBED DOES NOT AGREE WITH THAT WHICH YOU RECEIVED, PLEASE DESCRIBE THE DISCREPANCIES ON THE REVERSE SIDE OF THIS FORM AND GIVE THE FORM TO XXXXXXXXXXXXXXXXXXX. THANK YOU.

| PHYSICIAN, HOSPITAL, DRUGGIST, OR OTHER SUPPLIER OF MEDICAL SERVICE | DATE SERVICE WAS RENDERED | DESCRIPTION OF SERVICE | PAYMENT AMOUNT |
|---|---|---|---|
| DR. J. R. DOE | 11/28/71 | OFFICE VISIT | $10.00 |
| ACE INDEPENDENT LABORATORY | 11/30/71 | LAB TEST | $ 3.00 |
| GENERIC PHARMACY | 11/30/71 | PRESCRIPTION | $ 5.50 |
| DR. J. R. DOE | 12/02/71 | OFFICE VISIT, INJECTION | $12.00 |

202 312 313 301 314 349

IV-123

378

REPORT FORMAT SAMPLE

OUTPUT NO. CP-O-15

## E. SUBSYSTEM INPUTS

The Claims Processing Subsystem receives the inputs listed below. The purpose and source of each input are presented on an Input Definition Sheet. This sheet is followed by an Input Description Form that indicates the data elements that are introduced into the system by means of this input. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.


| Input Number | Input Name | Page Number |
|---|---|---|
| CP-I-Ø1 | Provider Claim | IV-127 |
| CP-I-Ø2 | Provider Credit | IV-131 |
| CP-I-Ø3 | Provider Adjustment | IV-133 |
| CP-I-Ø4 | Corrective Action Record | IV-135 |
| CP-I-Ø5 | Approved Prior Authorization | IV-137 |
| CP-I-Ø6 | Gross Adjustment | IV-139 |
| CP-I-Ø7 | Query | IV-141 |

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Claim | CP-I-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | Daily |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

1) Providers
2) Mail Room
3) Claims Auditor

**PURPOSE OF INPUT**

Contains all information required to properly render payment to the provider.

**REMARKS**

Claim format and content will vary depending on the type of provider who uses the claim.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Claim | CP-I-Ø1 |
| SUBSYSTEM NAME | DATE |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED | MINIMAL |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 107 | Recipient Sex | | X |
| 105 | Recipient Date of Birth | | X |
| 391 | Family Planning Code | X | |
| 303 | Attending Physician Number | X | |
| 304 | Referring Physician Number | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 310 | Billing Date | X | |
| 321 | Total Claim Charge | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 320 | Patient No. | | X |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 315 | Refill Indicator | X | |
| 311 | Admission Date | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 316 | Patient Status | X | |
| 317 | Discharged Patient's Destination | | X |
| 318 | Destination Provider Number | | X |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Claim | CP-I-Ø1 |
| SUBSYSTEM NAME | DATE |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 319 | Previous Provider Number | | X |
| 324 | Blood Furnished | | X |
| 325 | Blood Replaced | | X |
| 326 | Blood Not Replaced | X | |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 305 | Prescribing Physician Number | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 330 | Medicare Cash Deductible Amount | X | |
| 331 | Medicare Blood Deductible Amount | X | |
| 332 | Medicare Coinsurance Amount | X | |
| 333 | Medicare Coinsurance Days | X | |
| 340 | Prior Authorization Control Number | X | |
| 378 | Date of Surgery | X | |
| 379 | Leave Days | X | |
| 388 | Screening Results Code | X | |
| 389 | Screening Referral Code | X | |
| 390 | Screening Related Treatment | X | |
| 392 | Medicaid Deductible Amount | | X |
| 393 | Medicaid Copayment Amount | | X |
| 397 | Operating Physician Number | | X |
| 398 | Nature of Admission | | X |
| 399 | Certification Status | | X |
| 400 | Certification/Recertification Date | | X |
| 401 | Certification Review Indicator | | X |
| 402 | Days Certified Initially | | X |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Claim | CP-I-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED | MINIMAL |
|---|---|---|---|
| 403 | Total Days Certified | | X |
| 404 | Number of Requests for Extension | | X |
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# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Credit | CP-I-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | Daily |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

1) Providers
2) Mail Room
3) Credit and Adjustment Unit
4) Provider Subsystem

**PURPOSE OF INPUT**

Furnishes the data needed for the crediting of a previously paid claim.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Credit | CP-I-Ø2 |
| SUBSYSTEM NAME | DATE |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient Identification Number | X | |
| 201 | Provider Number | X | |
| 334 | Credit Number | X | |
| 327 | Units of Service of Claim Being Credited | X | |
| 300 | Transaction Control Number of Claim Being Credited | X | |
| 341 | Adjustment Code | | X |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Adjustment | CP-I-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | Daily |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

1) Providers
2) Mail Room
3) Credit and Adjustment Unit
4) Provider Subsystem

**PURPOSE OF INPUT**

Furnishes the data needed to adjust the amounts of a previously paid claim.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Provider Adjustment | CP-I-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 201 | Provider Number | X | |
| 335 | Adjustment Amount | X | |
| 336 | Adjustment for Units of Service | X | |
| 300 | Transaction Control Number of Claim Being Adjusted | X | |
| 341 | Adjustment Code | | X |
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# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Corrective Action Records | CP-I-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FREQUENCY** |
| Transaction Control Number | Daily |
| | **MEDIA** |
| | Keytape or card |

**SOURCE OF INPUT DATA**

Keyed from Transaction Exception Listing

**PURPOSE OF INPUT**

Serves to update claim transactions located on the Claims Processing Suspense File. The transactions are updated to enable them to be adjudicated.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Corrective Action Records | CP-I-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED | MINIMAL |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 337 | Correction Action Code | X | |
| 338 | Corrected Field Contents | X | |
| 339 | Error Code to be Overriden | X | |

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Approved Prior Authorization | CP-I-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8-1-71 |
| **SEQUENCE** | **FREQUENCY** |
| None | Daily |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

1) Providers
2) Medical Assistance Unit

**PURPOSE OF INPUT**

Sets up a record on the Claims Processing Suspense File. When a claim requiring prior authorization is processed, it will be disallowed unless a suspense authorization record is found authorizing the claim.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Approved Prior Authorization | CP-I-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED | MINIMAL |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 500 | Procedure Code | X | |
| 322 | Procedure Charge | X | |
| 387 | Approval Authority | | X |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Gross Adjustment | CP-I-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8-1-71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | Each payment cycle |
| | **MEDIA** |
| | Pre-printed Form |

**SOURCE OF INPUT DATA**

Finance and Accounting Unit

**PURPOSE OF INPUT**

Used to adjust a provider's account when the adjustment is not related to an individual claim (e.g., cost settlement adjustments, recovery of advances to providers).

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Gross Adjustment | CP-I-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 302 | Transaction Code | X | |
| 201 | Provider Number | X | |
| 335 | Adjustment Amount | X | |
| 341 | Adjustment Code | X | |
| 387 | Approval Authority | | X |
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# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Query | CP-I-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8-1-71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | Daily |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

1) Providers
2) Claims Processing Agency Personnel

**PURPOSE OF INPUT**

1) Requests the computer system to produce a query response indicating basic recipient data.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Query | CP-I-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 383 | Requestor | X | |
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## F. SUBSYSTEM FILES

The Claims Processing Subsystem utilizes the major files listed below. The purpose and nature of each file are presented on a File Definition Sheet. This sheet is followed by a File Description Form that indicates the data element that is maintained within the system by this file. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

A Data Element Input/Output Matrix for the Claims Processing Subsystem can be found on the last page in this section. This chart provides a summary of which data elements are introduced through the Claims Processing Subsystem and on which subsystem outputs these data elements are displayed.


| File Number | File Name | Page Number |
|---|---|---|
| CP-F-Ø1 | Batch Control Log | IV-145 |
| CP-F-Ø2 | Transaction Microfilm File | IV-147 |
| CP-F-Ø3 | Check Receipt Register | IV-149 |
| CP-F-Ø4 | Claims Processing Transaction File | IV-151 |
| CP-F-Ø5 | Claims Processing Control File | IV-155 |
| CP-F-Ø6 | Claims Processing Suspense File | IV-159 |
| CP-F-Ø7 | Adjudicated Claims File | IV-163 |
| PS-F-Ø1 | Provider Master File | IV-167 |
| RS-F-Ø1 | Medicaid Eligibility Master File | IV-171 |
| RF-F-Ø1 | Procedure, Diagnosis, and Formulary File | IV-173 |
| RF-F-Ø2 | Reasonable and Customary Charge File | IV-175 |
| RF-F-Ø3 | Current Skeletal History File | IV-177 |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Batch Control Log | CP-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Batch Number | ☐ EDP ☒ MANUAL |

**UPDATE PROCEDURE**

Updated daily as each batch of transactions is assembled and numbered.

**PURPOSE AND FUNCTION**

1) Provides a record of batch progress through the system.
2) Serves to verify integrity of EDP functions.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Batch Control Log | CP-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 308 | Batch Number | X | |
| 309 | Number of Transactions in Batch | X | |
| 342 | Date Claim Received | X | |
| 343 | Date Microfilmed | X | |
| 344 | Date Manually Audited | X | |
| 345 | Date Entered EDP | X | |
| 346 | Date Completed by EDP | X | |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Transaction Microfilm File | CP-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Transaction Control Number | ☐ EDP ☒ MANUAL |

**UPDATE PROCEDURE**

All transactions are microfilmed daily and added to this file.

**PURPOSE AND FUNCTION**

Provides easily accessible backup for all data entering system.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Transaction Microfilm File | CP-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED → | MINIMAL ↓ |
|---|---|---|---|
| | Contains photographic images of all transaction | | |
| | documents | | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Check Receipt Register | CP-F-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Sequence in which checks are received | ☐ EDP ☒ MANUAL |

**UPDATE PROCEDURE**

Each check received from a provider is entered on the register.

**PURPOSE AND FUNCTION**

1) Provides a record of all checks received.
2) Serves as an information source for creating credits and adjustments which will update the provider's account as a result of the returned check.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Check Receipt Register | CP-F-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 201 | Provider Number | X | |
| 202 | Provider Name | X | |
| 347 | Check Amount | X | |
| 300 | Transaction Control Number(s) of Claim(s) for Which | X | |
| | Payment is Returned (occurs as many times as | | |
| | necessary) | | |
| 348 | Reason for Return | X | |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Transaction File | CP-F-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Varies, depending on the stage of processing | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Created daily

**PURPOSE AND FUNCTION**

All transactions to be processed are assembled on this file. All processing steps of the Adjudication Module use this file as input and output.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Transaction File | CP-F-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 107 | Recipient Sex | X | |
| 106 | Recipient Race Code | X | |
| 105 | Recipient Date of Birth | X | |
| 108 | Recipient County Code | X | |
| 109 | Recipient Aid Category | X | |
| 391 | Family Planning Code | X | |
| 303 | Attending Physician Number | X | |
| 304 | Referring Physician Number | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 233 | Per Diem Rate | X | |
| 234 | Percent of Charges Factor | X | |
| 349 | Payment Amount | X | |
| 310 | Billing Date | X | |
| 321 | Total Claim Charge | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 320 | Patient No. | | X |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Transaction File | CP-F-Ø4 |
| SUBSYSTEM NAME | DATE |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 315 | Refill Indicator | X | |
| 311 | Admission Date | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 316 | Patient Status | X | |
| 317 | Discharged Patient's Destination | | X |
| 318 | Destination Provider Number | | X |
| 319 | Previous Provider Number | | X |
| 324 | Blood Furnished | | X |
| 325 | Blood Replaced | | X |
| 326 | Blood Not Replaced | X | |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 305 | Prescribing Physician Number | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 330 | Medicare Cash Deductible Amount | X | |
| 331 | Medicare Blood Deductible Amount | X | |
| 332 | Medicare Coinsurance Amount | X | |
| 350 | Date of Adjudication | X | |
| 351 | Adjudication Status | X | |
| 372 | Error Codes (occurs 10 times) | X | |
| 379 | Leave Days | X | |
| 378 | Date of Surgery | X | |
| 380 | Allowable Procedure Payment | X | |
| 381 | Professional Fee | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Transaction File | CP-F-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 377 | Override Codes | X | |
| 503 | Maximum Days Supply of Drug | X | |
| 384 | Type of Service | X | |
| 385 | Third Party Followup Flag | X | |
| 386 | Prescription Number | X | |
| 387 | Approval Authority | | X |
| 388 | Screening Results Code | X | |
| 389 | Screening Referral Code | X | |
| 390 | Screening Related Treatment | X | |
| 392 | Medicaid Deductible Amount | | X |
| 393 | Medicaid Copayment Amount | | X |
| 397 | Operating Physician Number | | X |
| 398 | Nature of Admission | | X |
| 399 | Certification Status | | X |
| 400 | Certification/Recertification Date | | X |
| 401 | Certification Review Indicator | | X |
| 402 | Days Certified Initially | | X |
| 403 | Total Days Certified | | X |
| 404 | Number of Requests for Extension | | X |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Control File | CP-F-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** [X] EDP [ ] MANUAL |
| Transaction Control Number | |

**UPDATE PROCEDURE**

Updated by all process steps which change the status of a transaction.

**PURPOSE AND FUNCTION**

1) Maintains the current status of all transactions which have not been adjudicated and all transactions adjudicated during the current month.
2) Maintains dollar and record count totals used to ensure accuracy of overall processing.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Control File | CP-F-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED | MINIMAL |
|---|---|---|---|
| 300 | Transaction Control | X | |
| 101 | Recipient ID Number | X | |
| 201 | Provider Number | X | |
| 352 | Date of Entry | X | |
| 353 | Transaction Status | X | |
| 312 | Beginning Date of Service | | X |
| 313 | Ending Date of Service | | X |
| 354 | Input Claims | X | |
| 355 | Input Credits and Adjustments | X | |
| 356 | Input Prior Authorizations | X | |
| 357 | Input Queries | X | |
| 358 | Suspense Claims | X | |
| 359 | Suspense Credits and Adjustments | X | |
| 360 | Suspense Prior Authorizations | X | |
| 361 | Previously Adjudicated Claims | X | |
| 362 | Previously Adjudicated Credits and Adjustments | X | |
| 363 | Suspense Transactions Deleted | X | |
| 364 | Total Charge Adjustments | X | |
| 365 | Matched Prior Authorizations | X | |
| 366 | Adjudicated Claims Output | X | |
| 367 | Adjudicated Credits and Adjustments Output | X | |
| 368 | Suspense Claim Output | X | |
| 369 | Suspense Credits and Adjustments Output | X | |
| 370 | Suspense Prior Authorizations Output | X | |
| 371 | Queries Printed | X | |
| 373 | Date of Transaction Status | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Control File | CP-F-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 372 | Error Codes | X | |
| 375 | Number of Corrective Action Attempts | X | |

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Transaction Control Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated by the Disposition Module daily

**PURPOSE AND FUNCTION**

1) All transactions which have entered the system and have not been adjudicated are maintained in this file.
2) All approved prior authorizations for which no claim has been received are also kept in this file.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 107 | Recipient Sex Code | X | |
| 106 | Recipient Race Code | X | |
| 105 | Recipient Date of Birth | X | |
| 108 | Recipient County Code | X | |
| 109 | Recipient Aid Category | X | |
| 391 | Family Planning Code | X | |
| 303 | Attending Physician Number | X | |
| 304 | Referring Physician Number | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 233 | Per Diem Rate | X | |
| 234 | Percent of Charges Factor | X | |
| 349 | Payment Amount | X | |
| 310 | Billing Date | X | |
| 321 | Total Claim Charge | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 320 | Patient No. | | X |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 315 | Refill Indicator | X | |
| 311 | Admission Date | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 316 | Patient Status | X | |
| 317 | Discharged Patient's Destination | | X |
| 318 | Destination Provider Number | | X |
| 319 | Previous Provider Number | | X |
| 324 | Blood Furnished | | X |
| 325 | Blood Replaced | | X |
| 326 | Blood Not Replaced | X | |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 305 | Prescribing Physician Number | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 330 | Medicare Cash Deductible Amount | X | |
| 331 | Medicare Blood Deductible Amount | X | |
| 332 | Medicare Coinsurance Amount | X | |
| 372 | Error Codes (occurs 10 times) | X | |
| 374 | Date Entered Suspense | X | |
| 375 | Number of Corrective Action Attempts | X | |
| 379 | Leave Days | X | |
| 378 | Date of Surgery | X | |
| 377 | Override Codes | X | |
| 386 | Prescription Number | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 387 | Approval Authority | | X |
| 333 | Medicare Coinsurance Days | X | |
| 388 | Screening Results Code | X | |
| 389 | Screening Referral Code | X | |
| 390 | Screening Related Treatment | X | |
| 392 | Medicaid Deductible Amount | | X |
| 393 | Medicaid Copayment Amount | | X |
| 397 | Operating Physician Number | | X |
| 398 | Nature of Admission | | X |
| 399 | Certification Status | | X |
| 400 | Certification/Recertification Date | | X |
| 401 | Certification Review Indicator | | X |
| 402 | Days Certified Initially | | X |
| 403 | Total Days Certified | | X |
| 404 | Number of Requests for Extension | | X |
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# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Adjudicated Claims File | CP-F-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| As required by Surveillance and Utilization Review Subsystem | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Created during each payment cycle.

**PURPOSE AND FUNCTION**

Collects all adjudicated claim transactions into one file for entry to the Surveillance and Utilization Review Subsystem.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Adjudicated Claims File | CP-F-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 107 | Recipient Sex Code | X | |
| 106 | Recipient Race Code | X | |
| 105 | Recipient Date of Birth | X | |
| 108 | Recipient County Code | X | |
| 109 | Recipient Aid Category | X | |
| 391 | Family Planning Code | X | |
| 303 | Attending Physician Number | X | |
| 304 | Referring Physician Number | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 349 | Payment Amount | X | |
| 310 | Billing Date | X | |
| 321 | Total Claim Charge | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 315 | Refill Indicator | X | |
| 311 | Admission Date | X | |
| 312 | Beginning Date of Service | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Adjudicated Claims File | CP-F-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 313 | Ending Date of Service | X | |
| 316 | Patient Status | X | |
| 317 | Discharged Patient's Destination | | X |
| 318 | Destination Provider Number | | X |
| 319 | Previous Provider Number | | X |
| 326 | Blood Not Replaced | X | |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 305 | Prescribing Physician Number | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 330 | Medicare Cash Deductible Amount | X | |
| 331 | Medicare Blood Deductible Amount | X | |
| 332 | Medicare Coinsurance Amount | X | |
| 376 | Payment Date | X | |
| 351 | Adjudication Status | X | |
| 378 | Date of Surgery | X | |
| 379 | Leave Days | X | |
| 380 | Allowable Procedure Payment | X | |
| 381 | Professional Fee | X | |
| 503 | Maximum Days Supply of Drug | X | |
| 384 | Type of Service | X | |
| 233 | Per Diem Rate | X | |
| 386 | Prescription Number | X | |
| 387 | Approval Authority | | X |
| 388 | Screening Results Code | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Adjudicated Claims File | CP-F-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 389 | Screening Referral Code | X | |
| 390 | Screening Related Treatment | X | |
| 392 | Medicaid Deductible Amount | | X |
| 393 | Medicaid Copayment Amount | | X |
| 397 | Operating Physician Number | | X |
| 398 | Nature of Admission | | X |
| 399 | Certification Status | | X |
| 400 | Certification/Recertification Date | | X |
| 401 | Certification Review Indicator | | X |
| 402 | Days Certified Initially | | X |
| 403 | Total Days Certified | | X |
| 404 | Number of Requests for Extension | | X |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Provider Master File | PS-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Provider Subsystem | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Provider Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Update daily if transactions are present.

**PURPOSE AND FUNCTION**

To retain provider related data to be used by the Claims Processing, Management and Administrative Reporting, and Surveillance and Utilization Review subsystems.

To provide a data base for maintenance, control, and efficient retrieval of information relating to providers.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Provider Master File | PS-F-Ø1 |
| SUBSYSTEM NAME | DATE |
| Provider Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 201 | Provider Number | X | |
| 202 | Provider Name | X | |
| 203 | Provider Address | X | |
| 204 | Provider Pay to Address | | X |
| 205 | Provider Type | X | |
| 301 | Category of Service | X | |
| 207 | Beginning Date of Service | X | |
| 208 | Ending Date of Service | X | |
| | (data elements 301 and 207 through 208 are repeated | | |
| | up to 10 times) | | |
| 209 | Provider Group Number | | X |
| 210 | Provider Type of Practice Organization | | X |
| 211 | Provider County Code | X | |
| 212 | Provider Employer Identification Number | X | |
| 213 | Provider Social Security Number | X | |
| 214 | Medicare Provider Number | | X |
| 215 | Provider Medicare Reimbursement Rates | | X |
| 216 | Provider Year End Date | | X |
| 217 | Provider License Number | | X |
| 218 | Provider License Board Code | | X |
| 219 | Provider License Date | | X |
| 220 | Provider Specialty Code | X | |
| 221 | Specialty Certification Number | | X |
| 222 | Specialty Certification Board Code | | X |
| 223 | Specialty Certification Date | | X |
| | (data elements 220 through 223 are repeated up to | | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Provider Master File | PS-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Provider Subsystem | 12/3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| | three times) | | |
| 224 | Date of Last Transaction | | X |
| 225 | Provider Exception Indicator | | X |
| 226 | Provider Credit Balance Amount | X | |
| 227 | Provider Credit Balance Date | X | |
| 228 | Provider Application Date | | X |
| 229 | Provider Rejection Reason Code | | X |
| 230 | Out of State Provider Code | | X |
| 231 | National Pharmacy Number | | X |
| 232 | Number of Beds Certified | | X |
| 233 | Per Diem Rate | X | |
| 234 | Percent of Charges Factor | X | |
| 235 | Rate Effective Date | X | |
| | (data elements 233 through 235 are repeated up to | | |
| | five times) | | |
| 236 | Provider Location Code | | X |
| 237 | Control of Medical Facility | | X |
| 238 | Provider Enrollment Status Code | X | |
| 239 | Provider Enrollment Status Date | X | |
| | (data elements 238 and 239 are repeated up to five | | |
| | times) | | |
| 241 | Number Physicians in Group | | X |
| 250 | Nursing Home Owners | X | |
| 251 | Review Committee Members | X | |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Medicaid Eligibility Master File | RS-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Recipient Subsystem | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Recipient Identification Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated daily

**PURPOSE AND FUNCTION**

The Medicaid Eligibility Master File contains one record for each Medicaid recipient who is eligible now or has been eligible during the past five years. This file contains all data items concerning individual recipients which is needed for claims payments and other related Medicaid activities. This file is updated every day that there are new eligibility transactions to process or eligibility errors to correct.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Medicaid Eligibility Master File | RS-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Recipient Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 101 | Recipient Identification Number | X | |
| 102 | Social Security Claim Number | X | |
| 103 | Recipient Name | X | |
| 104 | Recipient Address | X | |
| 105 | Recipient Date of Birth | X | |
| 106 | Recipient Race Code | X | |
| 107 | Recipient Sex Code | X | |
| 108 | Recipient County Code | X | |
| 109 | Recipient Aid Category | X | |
| 110 | Eligibility Begin Date | X | |
| 111 | Eligibility End Date | X | |
| | (data elements 108 through 111 are repeated ten times) | | |
| 112 | Date of Death | X | |
| 113 | Third Party Liability Code | X | |
| 114 | Buy-In Status Code | X | |
| 224 | Date of Last Transaction | | X |
| 116 | Recipient Exception Indicator | | X |
| 117 | Money Payment Code | X | |
| 118 | Medicare Type Code | | X |
| 122 | Date of Identification Card Issue | | X |
| | (data element 122 is repeated five times) | | |
| 123 | Buy-In Eligibility Date | X | |
| 124 | Scope of Coverage Code | | X |
| 132 | Recipient Eligibility Certification Date | X | |
| 133 | Recipient Location Code | | X |
| | | | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Medicaid Eligibility Master File | RS-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Recipient Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 134 | Social Security Account Number | X | |
| 135 | Gross Family Income | X | |
| 136 | Family Size | X | |
| 137 | Medicaid Premium Amount | X | |
| 138 | Medicaid Enrollment Fee Amount | X | |
| 392 | Medicaid Deductible Amount | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File | RF-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |
| **SEQUENCE** | **FILE TYPE** |
| Procedure Code<br>Diagnosis Code<br>Drug Code | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated on an as required basis by the Procedure, Diagnosis and Formulary Module of the Reference File Subsystem.

**PURPOSE AND FUNCTION**

1) Identifies valid procedure codes
2) Identifies valid diagnosis codes
3) Identifies valid drug codes
4) Cross-references consistent procedures and diagnoses
5) Indicates for each procedure and diagnosis logical age groups and sex
6) Stipulates the maximum allowable charges for procedures
7) Provides the wholesale cost of drugs.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File | RF-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 502 | Diagnosis Code | X | |
| 503 | Maximum Days Supply for Drug | X | |
| 505 | Drug Name | X | |
| 506 | Minimum Days Supply for Drug | X | |
| 507 | Drug Wholesale Cost | X | |
| 508 | Maximum Allowed Price | X | |
| 509 | Drug Classification | X | |
| 510 | Procedure Name | X | |
| 511 | Diagnosis Name | X | |
| 512 | Professional Fee Indicator | X | |
| 513 | Unit of Measure | X | |
| 514 | Package Quantity | X | |
| 524 | Valid Sex Indicator | X | |
| 525 | Age Range Indicator | X | |
| 527 | CRVS Conversion Factor | X | |
| 528 | Drug Cancellation Date | X | |
| 530 | Sub-file Indicator | X | |
| | | | |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Reasonable and Customary Charge File | RF-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Region Code<br>Provider Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated on request by the Reasonable and Customary Charge Module of the Reference File Subsystem

**PURPOSE AND FUNCTION**

Indicates for each region of a state and for each practitioner, the reasonable and customary charge for each medical procedure.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Reasonable and Customary Charge File | RF-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 526 | Region Code | X | |
| 201 | Provider Number | X | |
| 220 | Provider Specialty Code | X | |
| 500 | Procedure Code | X | |
| 384 | Type of Service | X | |
| 529 | Medicaid Reasonable Charge | X | |
| 531 | Medicare Reasonable Charge | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Current Skeletal History File | RF-F-Ø3 |
| **SUBSYSTEM NAME**<br>Reference File Subsystem | **DATE**<br>8/1/71 |
| **SEQUENCE**<br>Recipient Identification Number<br>Beginning Date of Service<br>Ending Date of Service | **FILE TYPE**<br>[X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

During the adjudication processing of the Claims Processing Subsystem, a record is created from each adjudicated claim and added to this file.

**PURPOSE AND FUNCTION**

This file is used for the detection of duplicate and conflicting claims.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Current Skeletal History File | RF-F-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | | X |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 108 | Recipient County Code | | X |
| 109 | Recipient Aid Category | | X |
| 306 | Primary Diagnosis Code | | X |
| 201 | Provider Number | X | |
| 349 | Payment Amount | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 315 | Refill Indicator | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 386 | Prescription Number | X | |
| 316 | Patient Status | | X |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 350 | Date of Adjudication | X | |
| 351 | Adjudication Status | X | |
| 384 | Type of Service | | X |
| | | | |

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# DATA ELEMENT
## INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Claims Processing

**INPUT**

| Provider Claims (CP-I-01) | Provider Credits (CP-I-02) | Provider Adjustments (CP-I-03) | Corrective Action Records (CP-I-04) | Approved Prior Authorizations (CP-I-05) | Gross Adjustments (CP-I-06) | Queries (CP-I-07) | Provider File (PS-F-01) | Recipient Eligibility Master File (RS-F-01) | Reasonable and Customary Charge File (RF-F-02) | Procedure, Diagnosis, and Formulary File (RF-F-01) | Current Skeletal History File (RF-F-03) | Claims Processing Control File (CP-F-05) | Claims Processing Suspense File (CP-F-06) | ELEMENT NUMBER | DATA ELEMENT NAME |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| X | X | X | | X | | X | | X | | X | | X | X | 101 | Recipient ID Number |
| X | | | | X | | | | X | | | | | X | 103 | Recipient Name |
| X | | | | | | | | X | | | | | X | 105 | Recipient Date of Birth |
| | | | | | | | | X | | | | | X | 106 | Recipient Race Code |
| X | | | | | | | | X | | | | | X | 107 | Recipient Sex Code |
| | | | | | | | | X | | | X | | X | 108 | Recipient County Code |
| | | | | | | | | X | | | X | | X | 109 | Recipient Aid Category |
| X | X | X | | X | X | | X | | X | | X | X | X | 201 | Provider Number |
| | | | | | | | X | | | | | | | 202 | Provider Name |
| | | | | | | | X | | | | | | | 203 | Provider Address |
| | | | | | | | X | | X | | | | | 220 | Provider Specialty Code |
| | | | | | | | X | | | | | | X | 233 | Per Diem Rate |
| | | | | | | | X | | | | | | X | 234 | Per Cent of Charges Factor |
| X | X | X | X | X | X | X | | | | | X | X | X | 300 | Transaction Control Number |
| X | X | X | | X | X | X | | | | | X | | X | 301 | Category of Service |
| X | | | | | | | | | | | X | | X | 302 | Transaction Code |
| X | | | | | | | | | | | | | X | 303 | Attending Physician Number |
| X | | | | | | | | | | | | | X | 304 | Referring Physician Number |
| X | | | | | | | | | | | | | X | 305 | Prescribing Physician Number |
| X | | | | X | | | | | | | X | | X | 306 | Primary Diagnosis Code |
| X | | | | X | | | | | | | | | X | 307 | Secondary Diagnosis Code |
| | | | | | | | | | | | | | | 308 | Batch Number |
| | | | | | | | | | | | | | | 309 | Number of Transactions in Batch |
| X | | | | | | | | | | | | | X | 310 | Billing Date |
| X | | | | | | | | | | | | | X | 311 | Admission Date |
| X | | | | | | | | | | | X | | X | 312 | Beginning Date of Service |
| X | | | | | | | | | | | X | | X | 313 | Ending Date of Service |
| X | | | | | | | | | | | X | | X | 314 | Place of Service |
| X | | | | | | | | | | | X | | X | 315 | Refill Indicator |
| X | | | | | | | | | | | X | | X | 316 | Patient Status |
| X | | | | | | | | | | | | | X | 317 | Discharged Patient's Destination |
| X | | | | | | | | | | | | | X | 318 | Destination Provider Number |
| X | | | | | | | | | | | | | X | 319 | Previous Provider Number |
| X | | | | | | | | | | | | | X | 320 | Patient Number |
| X | | | | X | | | | | | | X | | X | 321 | Total Claim Charge |
| X | | | | | | | | | | | X | | X | 322 | Procedure Charge |
| X | | | | | | | | | | | X | | X | 323 | Drug Charge |
| X | | | | | | | | | | | | | X | 324 | Blood Furnished |
| X | | | | | | | | | | | | | X | 325 | Blood Replaced |
| X | | | | | | | | | | | | | X | 326 | Blood Not Replaced |
| X | X | | | | | | | | | | X | | X | 327 | Units of Service |
| X | | | | | | | | | | | X | | X | 328 | Third Party Liability Action |
| X | | | | | | | | | | | X | | X | 329 | Third Party Liability Amount |
| X | | | | | | | | | | | | | X | 330 | Medicare Cash Deductible Amount |
| X | | | | | | | | | | | | | X | 331 | Medicare Blood Deductible Amount |
| X | | | | | | | | | | | | | X | 332 | Medicare Coinsurance Amount |
| X | | | | | | | | | | | | | X | 333 | Medicare Coinsurance Days |
| | X | | | | X | | | | | | | | | 334 | Credit Amount |
| | | X | | | | X | | | | | | | | 335 | Adjustment Amount |
| | | X | | | | | | | | | | | | 336 | Adjustment to Units of Service |
| | | | X | | | | | | | | | | | 337 | Correction Action Code |
| | | | X | | | | | | | | | | | 338 | Corrected Field Contents |
| | | | X | | | | | | | | | | | 339 | Error Code to be Overridden |
| X | | | | | X | | | | | | | | | 340 | Prior Authorization Control Number |
| | | | | | | | | | | | | | | 341 | Adjustment Code |
| | | | | | | | | | | | | | | 342 | Date Claim Received |
| | | | | | | | | | | | | | | 343 | Date Microfilmed |
| | | | | | | | | | | | | | | 344 | Date Manually Audited |
| | | | | | | | | | | | | | | 345 | Date Entered EDP |
| | | | | | | | | | | | | | | 346 | Date Completed by EDP |
| | | | | | | | | | | | | | | 347 | Check Amount |
| | | | | | | | | | | | | | | 348 | Reason for Return |
| | | | | | | | | | | | X | | | 349 | Payment Amount |
| | | X | | | | | | | | | | | | 350 | Date of Adjudication |
| | | X | | | | | | | | | | | | 351 | Adjudication Status |
| | X | | | | | | | | | | | | | 352 | Date of Entry |
| | X | | | | | | | | | | | | | 353 | Transaction Status |
| | X | | | | | | | | | | | | | 354 | Input Claims |
| | X | | | | | | | | | | | | | 355 | Input Credits and Adjustments |
| | X | | | | | | | | | | | | | 356 | Input Prior Authorization |
| | X | | | | | | | | | | | | | 357 | Input Queries |
| | X | | | | | | | | | | | | | 358 | Suspense Claims |
| | X | | | | | | | | | | | | | 359 | Suspense Credits and Adjustments |
| | X | | | | | | | | | | | | | 360 | Suspense Prior Authorizations |
| | X | | | | | | | | | | | | | 361 | Previously Adjudicated Claims |

**OUTPUT**

| Claims Processing Suspense File (CP-F-06) | Claims Processing Control File (CP-F-05) | Adjudicated Claims File (CP-F-07) | Current Skeletal History File (RF-F-03) | Explanation of Medical Benefits (CP-O-15) | Payment Summary (CP-O-14) | Check Register (CP-O-13) | Remittance Statements (CP-O-12) | Provider Checks (CP-O-11) | Daily Processing Log (CP-O-10) | Provider Query Responses (CP-O-09) | Internal Query Responses (CP-O-08) | Credit and Adjustment Control Summary (CP-O-07) | Transaction Register (CP-O-06) | Deceased Recipient Listing (CP-O-05) | Third Party Followup Report (CP-O-04) | Transaction Exception Listing (CP-O-03) | Disposition Processing Control Listing (CP-O-02) | Input Control Listing (CP-O-01) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| X | X | X | X | X | | X | | | X | X | X | | X | X | X | | | |
| X | | X | X | | | | | | | | X | | | | | | | |
| X | | X | X | | | | | | | | X | | | | | | | |
| X | | X | X | | | | | | | | X | | | | | | | |
| X | | X | X | | | | | | | | X | | | | | | | |
| X | | X | X | | | | | | | | X | | | | | | | |
| X | | X | X | X | | X | | | | X | X | X | X | | | | | |
| | | | | | | | | | | X | | | | | | | | |
| | | | | | | | | | | X | | | | | | | | |
| | | | | | | | | | | X | | | | | | | | |
| X | X | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| X | | X | X | | | | | | | | | | | | | | | |
| X | | X | X | | | | | | | | X | | X | | | | | |
| X | | X | X | | | | | | | | X | | X | | | | | |
| X | | X | X | X | | | | | | | | | | | | | | |
| X | | X | X | | | | | | | | X | | X | | | | | |
| X | | X | X | | | | | | | | | | | | | | | |
| X | | X | X | | | | | | | | | | | | | | | |
| X | | X | X | | | | | | | | | |

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# DATA ELEMENT
## INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Claims Processing

| INPUT | | |

# MEDICAID

# MANAGEMENT INFORMATION SYSTEM

## SECTION V

## REFERENCE FILE SUBSYSTEM

SECTION V

REFERENCE FILE SUBSYSTEM

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# V. REFERENCE FILE SUBSYSTEM

## A. SUBSYSTEM SUMMARY

### 1. Objectives

The Reference File Subsystem has been developed to accomplish the following primary objectives:

a. Provide an updating facility for the Model System Procedure, Diagnosis, and Formulary File.

b. Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.

c. Provide a Reasonable and Customary Charge File for Medicaid charges, Medicare charges, or both.

d. Enable the Reasonable and Customary Charge File to be updated.

e. Provide a means of transferring history records used for duplicate claims detection from an active file to a file used only periodically.

f. Generate various listings of the Claims Processing Suspense File.

### 2. General Description

Because this subsystem performs some rather diverse tasks, it is divided into four modules, each of which is independent and has little interaction with other subsystem modules. The modules are:

a. Procedure, Diagnosis, and Formulary -- this module provides update and listing support for the Procedure, Diagnosis, and Formulary File.

b. Reasonable and Customary Charge -- this module furnishes support to the Reasonable and Customary Charge File.

c. Skeletal History -- maintenance of the current and Master Skeletal History File is performed by this module.

d. Suspense File -- various listings of the Claims

Processing Suspense File are produced by this module.

The Reference File Subsystem interacts only with the Claims Processing Subsystem. All of the files supported are used solely for claims processing.

This subsystem differs from others in that most processing is done on an "as required" basis, rather than according to a preset schedule. All listing functions are performed on a request basis, with the exception of a scheduled "aged suspense file listing", and the updating procedures are done only when file changes are necessary.

## B. DESIGN ELEMENTS

### 1. Constraints and Assumptions

The Reference File Subsystem was designed based on the following constraints and assumptions:

a. It is assumed that the Procedure, Diagnosis and Formulary Files exist as partitions of the same logical file and reside on the same physical file device. This assumption was made in order to use generalized update and listing logic equally applicable to each of the three files. It also enables the processing of all three files with a minimum of manual intervention.

b. The proposed Model System computer configuration is assumed to provide enough direct access capability to support the storage of the Procedure, Diagnosis, and Formulary File, and the Reasonable and Customary Charge File in a direct access environment, although sequential processing could be used in this subsystem.

### 2. Design Considerations

During the development of the general design of the Reference File Subsystem, a number of design decisions were required in areas where more than one approach was feasible. An evaluation was conducted on the advantages and drawbacks connected with each alternative identified prior to adoption of a particular solution or approach for the model system. The discussions that follow summarize for each major item of consideration the alternatives explored and the resulting Model System recommendation.

#### a. Justification of Separate Subsystem

The initial design consideration concerned existence of a separate subsystem for reference file support. Since all subsystem files exist only for the Claims Processing Subsystem, a logical approach would be the inclusion of reference file support in that subsystem. However, the irregular processing schedule for reference files and the fact that reference

files could exist and be maintained independently of the Model System led to the decision to include their support as a separate subsystem.

b. Approach to File Maintenance

The second design consideration was whether or not to combine the Procedure, Diagnosis, and Formulary Files into a single file. The structure of the files is very similar, and their requirements for updating and listing are quite alike. Maintenance of three separate file support routines would create a great deal of subsystem redundancy. Therefore, it was decided to combine the files into a single file, which is partitioned into the three categories.

3. Controls and Audit Trails

In order to ensure that all information is processed both completely and accurately, the following controls and/or audit trails have been established:

a. Procedure, Diagnosis, and Formulary Error List -- this listing indicates all changes to the file which will not be processed because of erroneous data.

b. Procedure, Diagnosis, and Formulary Proof List -- all changes made to procedures, diagnoses, and formulary data is detailed on this listing.

c. Skeletal History File Summary -- a summarization and balancing of all history file changes is produced.

## C. PROCESSING FLOW

### 1. Introduction

A brief summary of each of the four modules comprising this subsystem is presented below:

a. Procedure, Diagnosis, and Formulary -- changes and requests for listings are input to the system. They are edited for errors and the error-free data is then used to update the file. Listings are produced as required by the input requests.

b. Reasonable and Customary Charge -- periodically history records or Medicare charge records or both are analyzed to determine changes in practitioner charge profiles, both individually and on an area basis.

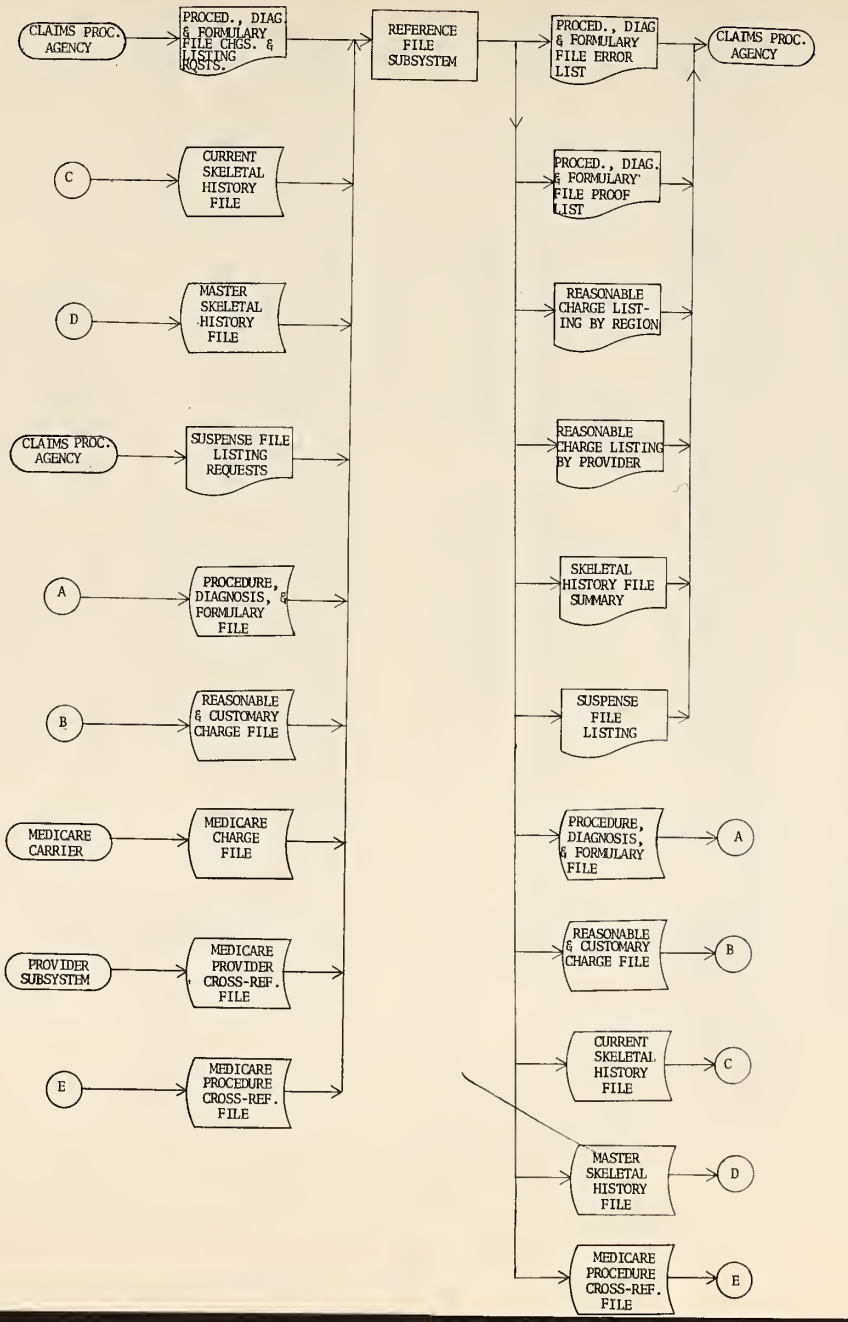
c. Skeletal History -- at intervals determined mainly by claim volume and filing limitations, skeletal history records used for duplicate claim detection are transferred from the Current Skeletal History File to the Master Skeletal History File.

d. Suspense File -- upon request the Claims Processing Suspense File is processed to generate listings.

### 2. Functional Flow Diagram

The Reference File Subsystem Functional Flow Diagram found on the following page graphically depicts the overall processing flow through the Reference File Subsystem.

# Reference File Subsystem Functional Flow Diagram



## 3. Module Descriptions

The Reference File Subsytem is comprised of the modules listed on this page. The remainder of this section is devoted to descriptions of these modules. Each module is described in turn in the following manner:

a. A brief description of major functions performed and outputs produced.

b. Processing Flowcharts.

c. Process Step Definitions, including special exhibits as required.

The Processing Flowchart provides a schematic of the processing flow within each module indicating each discrete processing step. Individual process steps are identified on the flowchart by a process step number of the form:

FX.YY

where F indicates the Reference File Subsystem

X indicates the module number

YY indicates the number of a process step within that module.

Immediately following the Processing Flowcharts are descriptions of the Activities or functions occurring at each process step within the module. These descriptions are presented on the Process Step Definition Sheets.


| Module Number | Module Name | Page Number |
|---|---|---|
| F1 | Procedure, Diagnosis and Formulary | V-9 |
| F2 | Reasonable and Customary Charge | V-13 |
| F3 | Skeletal History | V-17 |
| F4 | Suspense File. | V-21 |

## PROCEDURE, DIAGNOSIS, AND FORMULARY MODULE

### FUNCTIONS

The Procedure, Diagnosis, and Formulary Module performs the following major functions:

a. Receives all changes to and requests for listings of the Procedure, Diagnosis, and Formulary File.

b. Edits changes and requests for errors.

c. Produces a listing of all erroneous input.

d. Uses error-free input to update the files and generate report files.

e. Produces a proof list of all file changes.

f. Utilizes the report file to create requested listings.

### OUTPUTS

The Procedure, Diagnosis, and Formulary Module produces the following major outputs:

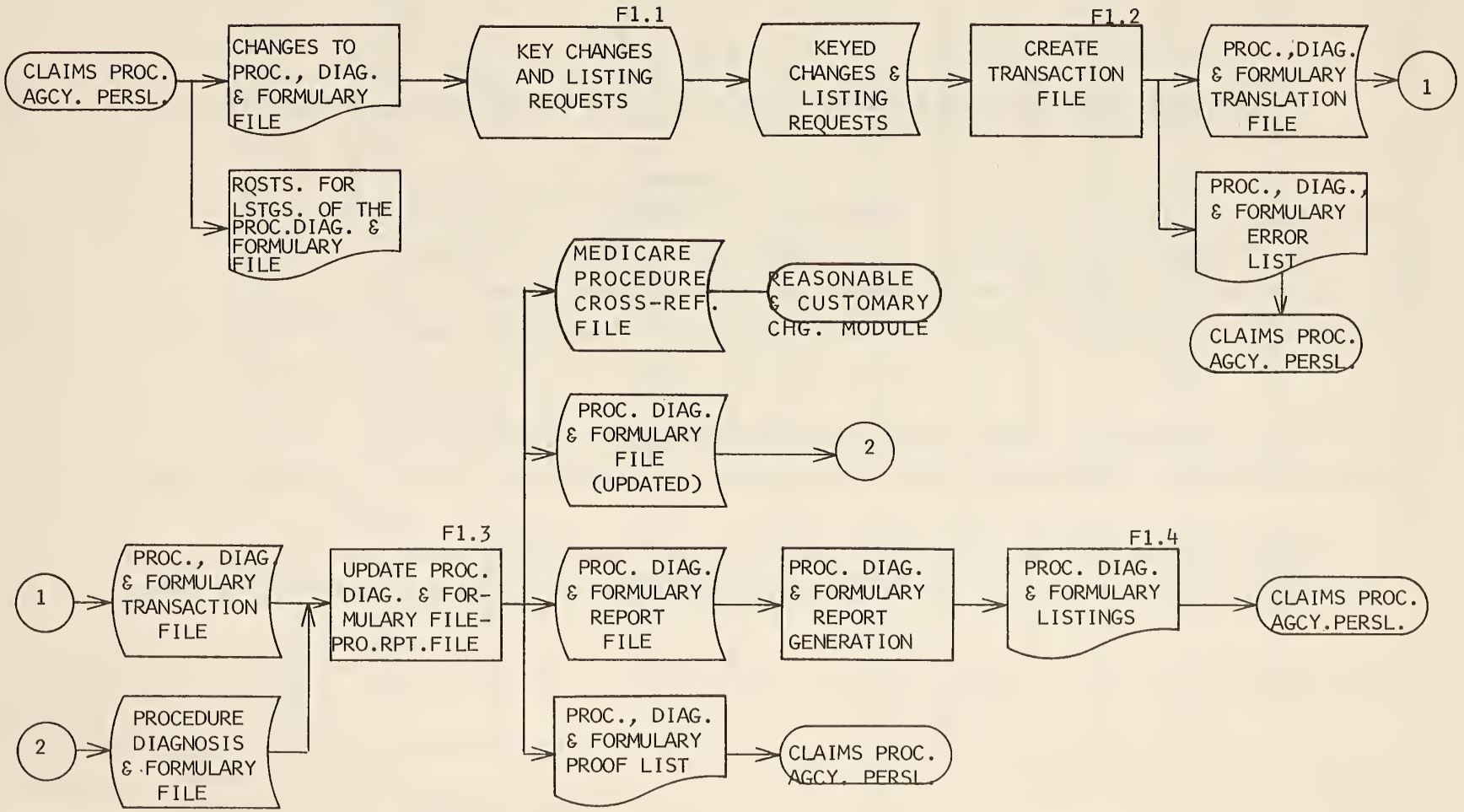
a. Procedure, Diagnosis, and Formulary Error List -- a listing of all changes and listing requests, which cannot be processed because of errors, is generated.

b. Procedure, Diagnosis, and Formulary Proof List -- a record of all changes made to the Procedure, Diagnosis, and Formulary File is produced.

c. Procedure, Diagnosis, and Formulary File Listing -- variously formatted and sequenced listings of the file are produced.

d. Medicare Procedure Cross-Reference File -- a file used to convert Medicare procedure codes to Medicaid procedure codes.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM REFERENCE FILE - PROCEDURE, DIAGNOSIS, AND FORMULARLY MODULE | |


CLAIMS PROC. AGCY. PERSL.
CHANGES TO PROC., DIAG. & FORMULARY FILE
F1.1
KEY CHANGES AND LISTING REQUESTS
KEYED CHANGES & LISTING REQUESTS
F1.2
CREATE TRANSACTION FILE
PROC.,DIAG. & FORMULARY TRANSLATION FILE
1
RQSTS. FOR LSTGS. OF THE PROC.DIAG. & FORMULARY FILE
PROC., DIAG., & FORMULARY ERROR LIST
CLAIMS PROC. AGCY. PERSL.
MEDICARE PROCEDURE CROSS-REF. FILE
REASONABLE & CUSTOMARY CHG. MODULE
PROC. DIAG. & FORMULARY FILE (UPDATED)
2
1
PROC., DIAG & FORMULARY TRANSACTION FILE
F1.3
UPDATE PROC. DIAG. & FORMULARY FILE-PRO.RPT.FILE
PROC. DIAG. & FORMULARY REPORT FILE
PROC. DIAG. & FORMULARY REPORT GENERATION
F1.4
PROC. DIAG. & FORMULARY LISTINGS
CLAIMS PROC. AGCY.PERSL.
2
PROCEDURE DIAGNOSIS & FORMULARY FILE
PROC., DIAG. & FORMULARY PROOF LIST
CLAIMS PROC. AGCY. PERSL.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM | Reference File | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| F1.1 | Data Preparation | Changes to and requests for listings of the Procedure, Diagnosis, and Formulary File are keyed to produce machine-readable data. |
| F1.2 | Data Processing | Keyed changes and requests are used to generate a transaction file. All changes and requests containing errors are displayed on an error report. |
| F1.3 | Data Processing | The transaction file from Step F1.2 is used to update the Procedure, Diagnosis, and Formulary File and to extract data necessary for requested listings. An updated file, a file for reporting, and a proof list of all changes are produced. A Medicare procedure conversion file is also produced. |
| F1.4 | Data Processing | The report file is used to produce all requested listings. |

# V. REFERENCE FILE SUBSYSTEM

## REASONABLE AND CUSTOMARY CHARGE MODULE

### FUNCTIONS

The Reasonable and Customary Charge Module performs the following major functions:

a. Extracts practitioner paid claim data from the Current and Master Skeletal History File.

b. Received Medicare practitioner charge data from the Title XVIII Part B Carrier.

c. Converts Medicare provider numbers to Medicaid provider numbers.

d. Converts Medicare procedure codes to Medicaid procedure codes.

e. Analyzes practitioner charge data for changes in charge profiles.

f. Produces records of changed charge profiles.

g. Updates, as necessary, the Reasonable and Customary Charge File.

h. Produces practitioner reasonable charge listings by practitioner and by region.

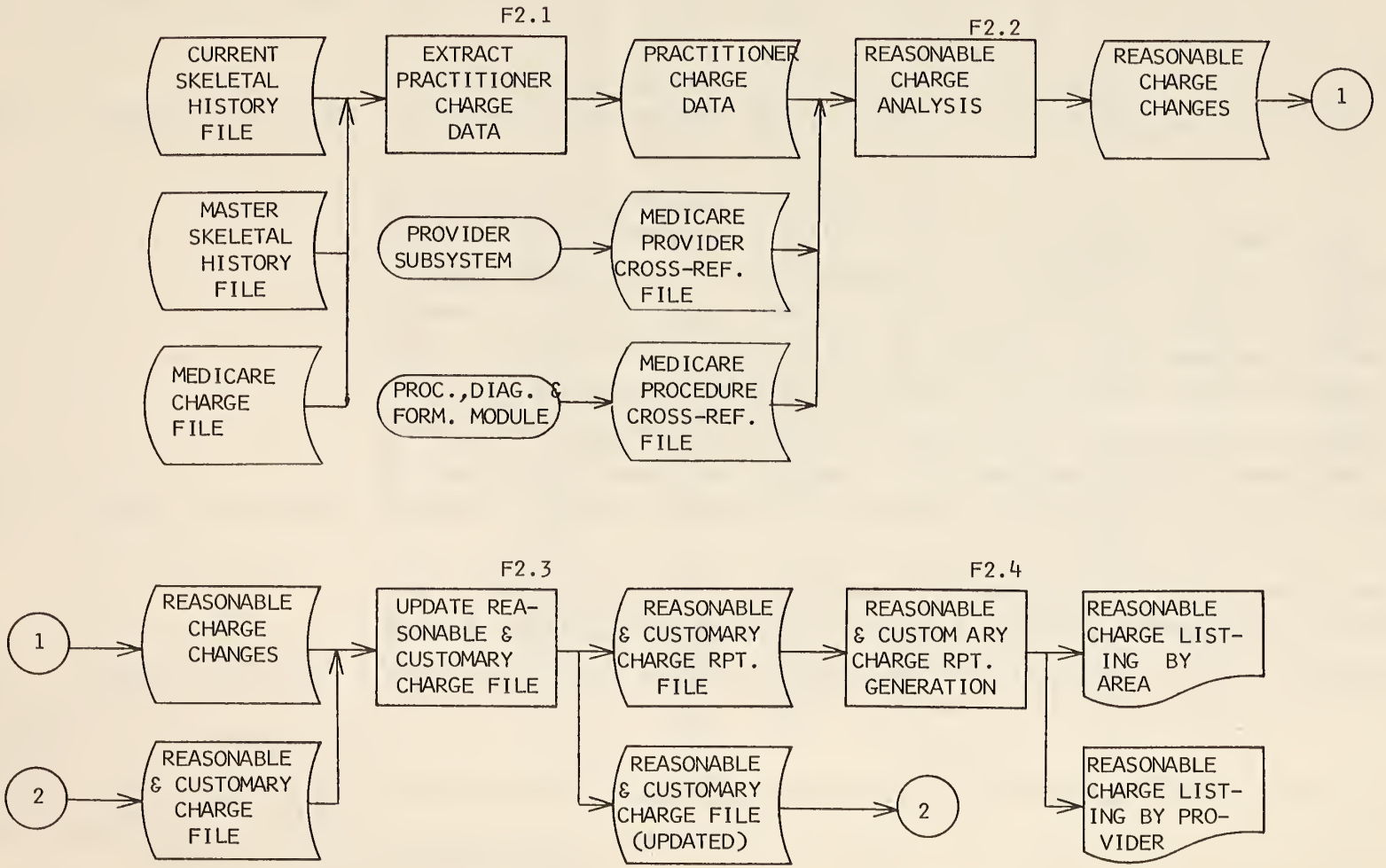
### OUTPUTS

The Reasonable and Customary Charge Module produces the following major outputs:

a. Reasonable Charge Listing by Region -- a report of reasonable and customary practitioner charges by region (for Medicaid and Medicare charges).

b. Reasonable Charge Listing by Provider -- a listing of each practitioner's reasonable and customary charges (for Medicaid and Medicare charges).

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM REFERENCE FILE - REASONABLE AND CUSTOMARY CHARGE MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM Reference File | | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| F2.1 | Data Processing | The Current and Master Skeletal History Files are used to extract Medicaid practitioner charge data and create a practitioner charge data file. The Medicare Charge File provides Medicare charge data. |
| F2.2 | Data Processing | Medicare provider numbers are converted to Medicaid provider numbers by use of the Medicare Provider Cross-Reference File. Medicare procedure codes are converted (if necessary) to Medicaid procedure codes by matching against the Medicare Procedure Cross-Reference File. Practitioner charge data is analyzed to determine changes and trends in practitioner charge profiles, both for individual practitioners and regions. The determination logic is based on individual States' requirements. A change file is generated to update the Reasonable and Customary Charge File. |
| F2.3 | Data Processing | The Reasonable and Customary Charge File is updated and a report file is generated containing details of reasonable and customary charges. |
| F2.4 | Data Processing | The report file produced by Step F2.3 is used to produce the Reasonable Charge listings by Region and Provider. |

# V. REFERENCE FILE SUBSYSTEM

## SKELETAL HISTORY MODULE

### FUNCTIONS

The Skeletal History Module performs the following major functions:

a. Transfer of older records from the Current Skeletal History File to the Master Skeletal History File.

b. Generation of a summary of history file transfers.

### OUTPUTS

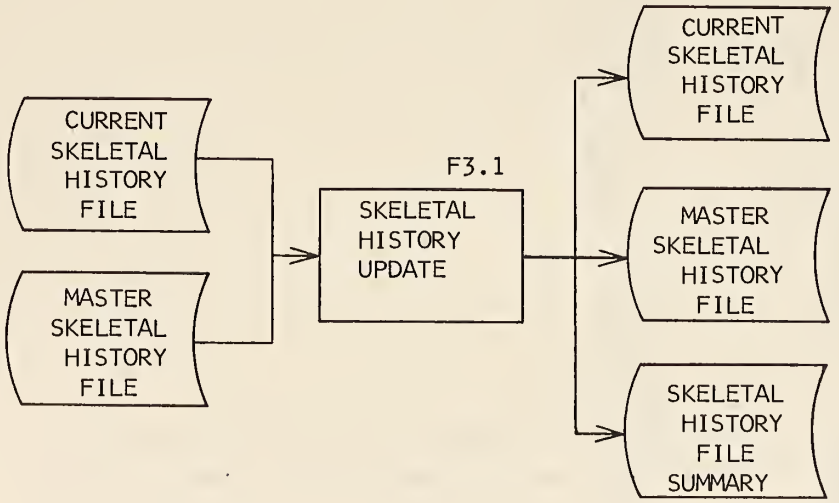
The Skeletal History Module produces the following major outputs:

a. Skeletal History File Summary -- a control report which indicates the proper transfer of records from one file to another.

b. Current Skeletal History File -- a copy of the previous Current Skeletal History File which has been purged of its oldest records.

c. Master Skeletal History File -- this is a copy of the input Master Skeletal History File to which have been added the records purged from the Current Skeletal History File.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM REFERENCE FILE - SKELETAL HISTORY MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM Reference File | | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| F3.1 | Data Processing | All current skeletal history records older than a specified age are transferred to the Master Skeletal History File. The purged Current and updated Master Skeletal History File, as well as the Skeletal History File Summary are output. |

# V. REFERENCE FILE SUBSYSTEM

## SUSPENSE FILE MODULE

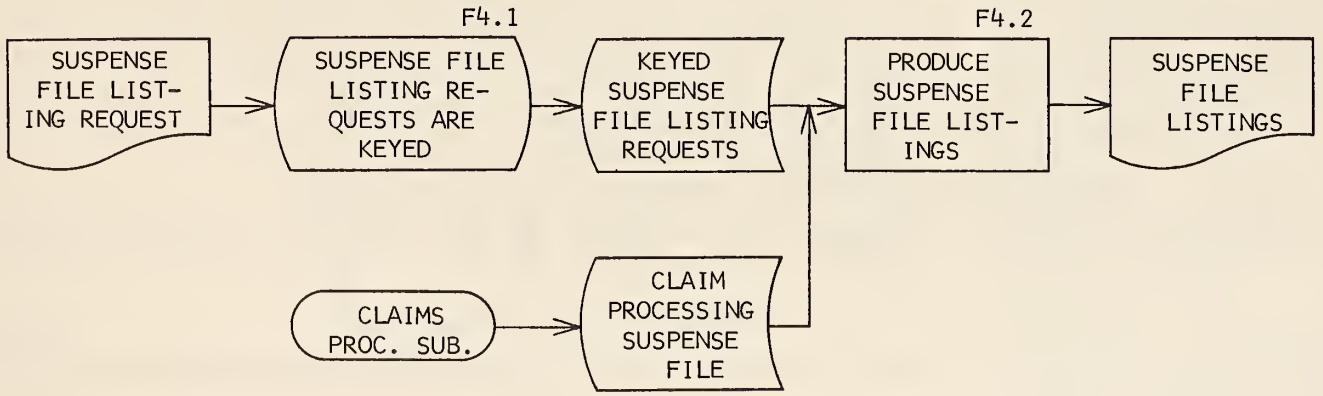
### FUNCTIONS

The Suspense File Module has the function of producing reports based on data from the Claims Processing Suspense File. Typical reports include a scheduled aged listing, a listing of all transactions suspended because of a certain error condition, and all suspended claims for a given provider.

### OUTPUTS

The only outputs produced by the Suspense File Module are various listings, similar in format but different in sequence, of the Claims Processing Suspense File.

| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM<br>GENERAL DESIGN DOCUMENTATION | PROCESSING FLOWCHART |
|---|---|
| SUBSYSTEM REFERENCE FILE - SUSPENSE FILE MODULE | |



| MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION | | PROCESS STEP DEFINITION |
|---|---|---|
| SUBSYSTEM Reference File | | |
| PROCESS STEP NO. | RESPONSIBILITY | ACTIVITY |
| F4.1 | Data Preparation Unit | Requests for Claims Processing Suspense File listings are converted to machine-readable format. |
| F4.2 | Data Processing | Keyed listing requests are processed against the Claims Processing Suspense File to produce the required listings. |

## D. SUBSYSTEM OUTPUTS

The Reference File Subsystem produces the outputs listed below. The purpose, distribution, and sequence of each output are presented on an Output Definition Sheet. Whenever practical this sheet is followed by a sample report layout that describes the general format and content of the report. The data displayed on the reports are entirely fictitious with little regard given to reasonableness or cross footing of the numbers. The purpose of the sample data is solely one of assistance to the reader in more readily gaining an understanding of the report. The three digit numbers that appear on each report are data element numbers identifying the data elements contained within that report. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.


| Output Number | Output Name | Page Number |
|---|---|---|
| RF-0-Ø1 | Procedure, Diagnosis, and Formulary Error List | V-26 |
| RF-0-Ø2 | Procedure, Diagnosis, and Formulary Proof List | V-28 |
| RF-0-Ø3 | Procedure, Diagnosis, and Formulary File Listing | V-30 |
| RF-0-Ø4 | Reasonable Charge Listing By Region | V-32 |
| RF-0-Ø5 | Reasonable Charge Listing By Provider | V-34 |
| RF-0-Ø6 | Suspense File Listing | V-36 |
| RF-0-Ø7 | Skeletal History File Summary | V-38 |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary Error List | RF-0-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Procedure, Diagnosis, and Formulary Module Process Step F1.2 | As required |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | In sequence of input changes and | 4. | |
| 2. | requests | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

Indicates those changes and listing requests which will not be processed because of error conditions.

**REMARKS**

# PROCEDURE FORMULARY AND DIAGNOSIS ERROR LIST

| ERRONEOUS TRANSACTION | ERROR MESSAGE |
|---|---|
| 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 524 525 | |
| X----------*TRANSACTION IMAGE*----------X | INVALID TRANSACTION CODE |
| X X X X *TRANSACTION IMAGE* X X X X X X X X | INVALID DRUG CODE |

527 528

| | PROCEDURE | DIAGNOSIS | FORMULARY |
|---|---|---|---|
| TRANSACTIONS READ | 15 | 21 | 103 |
| TRANSACTIONS ACCEPTED | 14 | 21 | 102 |
| TRANSACTIONS IN ERROR | 1 | 0 | 1 |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-O-01

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary Proof List | RF-0-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Procedure, Diagnosis, and Formulary Module Process Step F1.3 | As required |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Procedure, Diagnosis, and/or | 4. | |
| 2. | Drug Code | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

Provides an audit trail which shows all changes applied to the Procedure, Diagnosis, and Formulary File.

**REMARKS**

RUN DATE 01/01/72 PAGE 1

# PROCEDURE DIAGNOSIS AND FORMULARY PROOF LIST

| FILE UPDATED | CODE | ACTION TAKEN | OUTPUT RECORD IMAGE |
|---|---|---|---|
| | | | 500 501 502 503 504 505 506 507 508 509 510 511 |
| PROC | 91020 | ADDED | *-*-*-*-*-*-*-TRANSACTION IMAGE-*-*-*-*-*-*-*-*-*-*-* |
| PROC | 93360 | CHANGED FIELD NO. 07 FROM 6283 TO 6280 | *-*-*-*-*-*-*-TRANSACTION IMAGE-*-*-*-*-*-*-*-*-*-*-* |
| DIAG | 2740 | DELETED | |
| DIAG | 6510 | CHANGED FIELD NO. 14 FROM 00400 TO 00450 | *-*-*-*-*-*-*-TRANSACTION IMAGE-*-*-*-*-*-*-*-*-*-*-* |
| FORM | OTC-15813 | ADDED | *-*-*-*-*-*-*-TRANSACTION IMAGE-*-*-*-*-*-*-*-*-*-*-* |
| FORM | 107-34567 | NOT PROCESSED--NO MATCHING MASTER FILE RECORD | |
| FORM | 238-65432 | DELETED | 512 513 514 515 524 525 527 528 |

500 501 504

502

| FILE | INPUT | +ADDITIONS | -DELETES | =OUTPUT | CHANGES | ERRORS NOT PROCESSED |
|---|---|---|---|---|---|---|
| PROCEDURE | 2407 | 1 | 0 | 2408 | 1 | 0 |
| DIAGNOSIS | 3216 | 0 | 1 | 3215 | 1 | 0 |
| FORMULARY | 2284 | 1 | 1 | 2284 | 0 | 1 |
| TOTALS | 7907 | 2 | 2 | 7907 | 2 | 1 |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-0-02

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File Listing | RF-0-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Procedure, Diagnosis, and Formulary Module Process Step F1.4 | As requested |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Requestor |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | As specified by requestor | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

Provides various listings, the format and sequence of which are specified by the requestor, of the Procedure, Diagnosis, and Formulary File.

**REMARKS**

# PROCEDURE DIAGNOSIS AND FORMULARY FILE LISTING

FILE BEING LISTED--PROCEDURE
FORMAT-- CONDENSED
SEQUENCE-- PROCEDURE CODE

| PROCEDURE CODE | TYPE OF SERVICE | VALID DIAGNOSES |
|---|---|---|
| 0100 | 01 | 2830 2833 4790 5380 |
| | 02 | 2830 2833 4790 6150 |
| 0101 | 01 | 1650 1660 |
| | 02 | 1650 1660 1670 |
| | 03 | 1650 1660 |
| 500 | 383 | 502 |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-O-03

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Reasonable Charge Listing by Region | RF-0-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Reasonable and Customary Charge Module<br>Process Step F2.4 | As required |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Region Code | 4. | Type of Service |
| 2. | Provider Specialty Code | 5. | |
| 3. | Procedure Code | 6. | |

**PURPOSE OF OUTPUT**

Provides a listing of reasonable charge data for various regions of the State.

**REMARKS**

# REASONABLE CHARGE LISTING BY REGION

| REGION CODE | SPECIALTY CODE | PROCEDURE CODE | TYPE OF SERVICE | MEDICAID REASONABLE CHARGE | MEDICARE REASONABLE CHARGE |
|---|---|---|---|---|---|
| 01 | 01 | 42860 | 01 | 15.00 | 17.00 |
| | | | 02 | 14.00 | 16.00 |
| | | | 03 | 12.00 | 13.00 |
| | | | 04 | 13.00 | 15.00 |
| | | 42900 | 01 | 20.00 | 24.00 |
| | | | 02 | 20.00 | 25.00 |
| | 02 | 42860 | 01 | 14.00 | 16.00 |
| | | | 02 | 14.00 | 16.00 |
| | | 42900 | 01 | 19.00 | 22.00 |
| | | | 02 | 19.00 | 22.00 |
| 02 | 01 | 42860 | 01 | 18.00 | 20.00 |
| **526** | **220** | **500** | **384** | **529** | 531 |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-0-04

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Reasonable Charge Listing by Provider | RF-0-Ø5 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SOURCE OF OUTPUT DATA | FREQUENCY |
|---|---|
| Reasonable and Customary Charge Module<br>Process Step F2.4 | As required |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Provider Number | 4. | |
| 2. | Procedure Code | 5. | |
| 3. | Type of Service | 6. | |

**PURPOSE OF OUTPUT**

Provides a listing of each practitioner's reasonable charges.

**REMARKS**

# REASONABLE CHARGE LISTING BY PROVIDER

| PROVIDER NO. | REGION CODE | SPECIALTY CODE | PROCEDURE CODE | TYPE OF SERVICE | MEDICAID REASONABLE CHARGE | MEDICARE REASONABLE CHARGE |
|---|---|---|---|---|---|---|
| 1234567 | 08 | 03 | 21600 | 01 | 6.00 | 7.00 |
| | | | | 02 | 6.00 | 7.00 |
| | | | 21630 | 01 | 10.00 | 12.00 |
| | | | | 02 | 9.00 | 12.00 |
| 2345678 | 03 | 01 | 21600 | 01 | 5.00 | 5.00 |
| | | | | 02 | 5.00 | 6.00 |
| | | | 21630 | 01 | 7.00 | 9.00 |
| | | | | 02 | 7.00 | 9.00 |
| 201 | 526 | 220 | 500 | 384 | 529 | 531 |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-0-05

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Suspense File Listing | RF-0-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Suspense File Module<br>Process Step F4.2 | As requested |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Requester |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | Specified by requester | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

Provides various listings of the Claims Processing Suspense File, in sequences specified by the requester

**REMARKS**

An aged listing is requested on a regularly scheduled basis.

# SUSPENSE FILE LISTING

| TRANSACTION CONTROL NO. | PROVIDER NO. | RECIPIENT ID NO. | DATE ENTERED SUSPENSE | NO. OF CORRECTION ATTEMPTS | TRANSACTION ERROR CODES |
|---|---|---|---|---|---|
| 1338T00702 | 1245780 | 1234567890 | 09/07/71 | 2 | 007 286 |
| 1338V02807 | 9876543 | 2345678901 | 09/07/71 | 1 | 318 |
| 1341A04413 | 3456789 | 3456789012 | 09/10/71 | 0 | 064 065 |
| **300** | **201** | **101** | **374** | **375** | **372** |



REPORT FORMAT SAMPLE

OUTPUT NO. RF-O-06

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# OUTPUT DEFINITION

| OUTPUT NAME | OUTPUT NO. |
|---|---|
| Skeletal History File Summary | RF-0-Ø7 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SOURCE OF OUTPUT DATA** | **FREQUENCY** |
| Skeletal History File Module<br>Process Step F3.1 | As required |
| | **MEDIA** |
| | Stock Paper |

**DISTRIBUTION**

| | |
|---|---|
| 1. | Claims Processing Unit |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**SEQUENCE**

| | | | |
|---|---|---|---|
| 1. | None | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**PURPOSE OF OUTPUT**

Provides a summary of skeletal history file transfers from current file to master file.

**REMARKS**

RUN DATE 01/01/72

PAGE 1

# H I S T O R Y  F I L E  S U M M A R Y

| INPUT | RECORDS | PAYMENT AMOUNT |
|---|---|---|
| MASTER SKELETAL HISTORY | 16,283,115 | 193,418,262.83 |
| CURRENT SKELETAL HISTORY | 786,209 | 9,833,641.16 |
| TOTAL INPUT | 17,069,324 | 203,251,803.99 |
| | | |
| OUTPUT | | |
| MASTER SKELETAL HISTORY | 16,528,963 | 196,593,620.47 |
| CURRENT SKELETAL HISTORY | 540,361 | 6,658,183.52 |
| TOTAL OUTPUT | 17,069,324 | 203,251,803.99 |

347

V-39

REPORT FORMAT SAMPLE

OUTPUT NO. RF-O-07

## E. SUBSYSTEM INPUTS

The Reference File Subsystem receives the inputs listed below. The purpose and source of each input are presented on an Input Definition Sheet. This sheet is followed by an Input Description Form that indicates the data elements that are introduced into the system by means of this input. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements, and where applicable, a recommended coding structure can be found in the Appendix.


| Input Number | Input Name | Page Number |
|---|---|---|
| RF-I-Ø1 | Procedure, Diagnosis, and Formulary File Changes | V-43 |
| RF-I-Ø2 | Procedure, Diagnosis, and Formulary File Listing Requests | V-45 |
| RF-I-Ø3 | Suspense File Listing Requests | V-47 |
| RF-I-Ø4 | Medicare Charge File | V-48.1 |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File Change | RF-I-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SEQUENCE** | **FREQUENCY** |
| None | As required |
| | **MEDIA** |
| | Pre-Printed Form |

**SOURCE OF INPUT DATA**

Claims Processing Unit

**PURPOSE OF INPUT**

Provides source data for making additions, changes, and deletions to the Procedure, Diagnosis, and Formulary File.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File Change | RF-I-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 502 | Diagnosis Code | X | |
| 504 | Reference File Transaction Code | X | |
| 505 | Drug Name | X | |
| 506 | Minimum Days Supply of Drug | X | |
| 503 | Maximum Days Supply of Drug | X | |
| 507 | Drug Wholesale Cost | X | |
| 508 | Maximum Allowed Price | X | |
| 509 | Drug Classification | X | |
| 510 | Procedure Name | X | |
| 511 | Diagnosis Name | X | |
| 512 | Professional Fee Indicator | X | |
| 513 | Unit of Measure | X | |
| 514 | Package Quantity | X | |
| 515 | Reference File Change Field | X | |
| 524 | Valid Sex Indicator | X | |
| 525 | Age Range Indicator | X | |
| 527 | CRVS Conversion Factor | X | |
| 528 | Drug Cancellation Date | X | |
| 532 | Medicare Procedure Code | X | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File Listing Request | RF-I-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | As required |
| | **MEDIA** |
| | Pre-printed Form |

**SOURCE OF INPUT DATA**

Claims Processing Agency Personnel

**PURPOSE OF INPUT**

1) To request listings of the Procedure, Diagnosis, and Formulary File.
2) To specify the content, format, and sequence of the listing.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Procedure, Diagnosis, and Formulary Listing Request | RF-I-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 516 | Procedure Indicator | X | |
| 517 | Procedure Format | X | |
| 518 | Diagnosis Indicator | X | |
| 519 | Diagnosis Format | X | |
| 520 | Formulary Indicator | X | |
| 521 | Formulary Format | X | |

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Suspense File Listing Request | RF-I-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| SEQUENCE | FREQUENCY |
|---|---|
| None | As required |
| | **MEDIA** |
| | Pre-printed form |

**SOURCE OF INPUT DATA**

Claims Processing Agency Personnel

**PURPOSE OF INPUT**

1) Requests a listing of the Claims Processing Suspense File.
2) Specifies the content and sequence of the listing.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Suspense File Listing Request | RF-I-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 522 | Listing Content | X | |
| 523 | Listing Sequence | X | |

# INPUT DEFINITION

| INPUT NAME | INPUT NO. |
|---|---|
| Medicare Charge File | RF-I-04 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

**SEQUENCE**

Region Code
Medicare Provider Number
Provider Specialty Code
Procedure Code

**FREQUENCY**

As required

**MEDIA**

Tape(or cards or disk)

**SOURCE OF INPUT DATA**

Medicare Part B Carrier

**PURPOSE OF INPUT**

1) Provides usual and customary charge data on Medicare practitioners.
2) Provides area prevailing charge data on Medicare procedures.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# INPUT DESCRIPTION

| INPUT NAME | INPUT NO. |
|---|---|
| Medicare Charge File | RF-I-04 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 526 | Region Code | X | |
| 214 | Medicare Provider Number | X | |
| 220 | Provider Specialty Code | X | |
| 532 | Medicare Procedure Code | X | |
| 384 | Type of Service | X | |
| 531 | Medicare Reasonable Charge | X | |
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## F. SUBSYSTEM FILES

The Reference File Subsystem utilizes the major files listed below. The purpose and nature of each file are presented on a File Definition Sheet. This sheet is followed by a File Description Form that indicates the data element that is maintained within the system by this file. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

A Data Element Input/Output Matrix for the Reference File Subsystem can be found on the last page in this section. This chart provides a summary of which data elements are introduced through the Reference File Subsystem and on which subsystem outputs these data elements are displayed.


| File Number | File Name | Page Number |
|---|---|---|
| RF-F-Ø1 | Procedure, Diagnosis, and Formulary File | V-51 |
| RF-F-Ø2 | Reasonable and Customary Charge File | V-53 |
| RF-F-Ø3 | Current Skeletal History File | V-55 |
| RF-F-Ø4 | Master Skeletal History File | V-57 |
| CP-F-Ø6 | Claims Processing Suspense File | V-59 |
| RF-F-Ø5 | Medicare Provider Cross-Reference File | V-62.1 |
| RF-F-Ø6 | Medicare Procedure Cross-Reference File | V-62.3 |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File | RF-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/3/73 |
| **SEQUENCE** | **FILE TYPE** |
| Procedure Code<br>Diagnosis Code<br>Drug Code | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated on an as required basis by the Procedure, Diagnosis and Formulary Module of the Reference File Subsystem.

**PURPOSE AND FUNCTION**

1) Identifies valid procedure codes
2) Identifies valid diagnosis codes
3) Identifies valid drug codes
4) Cross-references consistent procedures and diagnoses
5) Indicates for each procedure and diagnosis logical age groups and sex
6) Stipulates the maximum allowable charges for procedures
7) Provides the wholesale cost of drugs.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Procedure, Diagnosis, and Formulary File | RF-F-Ø1 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | |
|---|---|---|---|
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 502 | Diagnosis Code | X | |
| 503 | Maximum Days Supply for Drug | X | |
| 505 | Drug Name | X | |
| 506 | Minimum Days Supply for Drug | X | |
| 507 | Drug Wholesale Cost | X | |
| 508 | Maximum Allowed Price | X | |
| 509 | Drug Classification | X | |
| 510 | Procedure Name | X | |
| 511 | Diagnosis Name | X | |
| 512 | Professional Fee Indicator | X | |
| 513 | Unit of Measure | X | |
| 514 | Package Quantity | X | |
| 524 | Valid Sex Indicator | X | |
| 525 | Age Range Indicator | X | |
| 527 | CRVS Conversion Factor | X | |
| 528 | Drug Cancellation Date | X | |
| 530 | Sub-file Indicator | X | |
| 532 | Medicare Procedure Code | X | |
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MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Reasonable and Customary Charge File | RF-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Region Code<br>Provider Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated on request by the Reasonable and Customary Charge Module of the Reference File Subsystem

**PURPOSE AND FUNCTION**

Indicates for each region of a state and for each practitioner, the reasonable and customary charge for each medical procedure.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Reasonable and Customary Charge File | RF-F-Ø2 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 526 | Region Code | X | |
| 201 | Provider Number | X | |
| 220 | Provider Specialty Code | X | |
| 500 | Procedure Code | X | |
| 384 | Type of Service | X | |
| 529 | Medicaid Reasonable Charge | X | |
| 531 | Medicare Reasonable Charge | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Current Skeletal History File | RF-F-Ø3 |
| **SUBSYSTEM NAME**<br>Reference File Subsystem | **DATE**<br>8/1/71 |
| **SEQUENCE**<br>Recipient Identification Number<br>Beginning Date of Service<br>Ending Date of Service | **FILE TYPE**<br>[X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

During the adjudication processing of the Claims Processing Subsystem, a record is created from each adjudicated claim and added to this file.

**PURPOSE AND FUNCTION**

This file is used for the detection of duplicate and conflicting claims.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Current Skeletal History File | RF-F-Ø3 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | | X |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 108 | Recipient County Code | | X |
| 109 | Recipient Aid Category | | X |
| 306 | Primary Diagnosis Code | | X |
| 201 | Provider Number | X | |
| 349 | Payment Amount | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |
| 315 | Refill Indicator | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 386 | Prescription Number | X | |
| 316 | Patient Status | | X |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 350 | Date of Adjudication | X | |
| 351 | Adjudication Status | X | |
| 384 | Type of Service | | X |
| | | | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Master Skeletal History File | RF-F-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Recipient Identification Number<br>Beginning Date of Service<br>Ending Date of Service | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

This file is updated by the Skeletal History Module of the Reference File Subsystem

**PURPOSE AND FUNCTION**

This file is used to check for duplicate and conflicting claims which are too old to be checked with the Current Skeletal History File.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Master Skeletal History Code | RF-F-Ø4 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 8/1/71 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| | This file is identical to the Current Skeletal | | |
| | History File (RF-0-Ø3) in data element content. | | |

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 8/1/71 |
| **SEQUENCE** | **FILE TYPE** |
| Transaction Control Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

Updated by the Disposition Module daily

**PURPOSE AND FUNCTION**

1) All transactions which have entered the system and have not been adjudicated are maintained in this file.
2) All approved prior authorizations for which no claim has been received are also kept in this file.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 300 | Transaction Control Number | X | |
| 301 | Category of Service | X | |
| 302 | Transaction Code | X | |
| 101 | Recipient ID Number | X | |
| 103 | Recipient Name | X | |
| 107 | Recipient Sex Code | X | |
| 106 | Recipient Race Code | X | |
| 105 | Recipient Date of Birth | X | |
| 108 | Recipient County Code | X | |
| 109 | Recipient Aid Category | X | |
| 391 | Family Planning Code | X | |
| 303 | Attending Physician Number | X | |
| 304 | Referring Physician Number | X | |
| 306 | Primary Diagnosis Code | X | |
| 307 | Secondary Diagnosis Code | X | |
| 201 | Provider Number | X | |
| 233 | Per Diem Rate | X | |
| 234 | Percent of Charges Factor | X | |
| 349 | Payment Amount | X | |
| 310 | Billing Date | X | |
| 321 | Total Claim Charge | X | |
| 328 | Third Party Liability Action | X | |
| 329 | Third Party Payment Amount | X | |
| 320 | Patient No. | | X |
| 500 | Procedure Code | X | |
| 501 | Drug Code | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL → | ↓ |
|---|---|---|---|
| 315 | Refill Indicator | X | |
| 311 | Admission Date | X | |
| 312 | Beginning Date of Service | X | |
| 313 | Ending Date of Service | X | |
| 316 | Patient Status | X | |
| 317 | Discharged Patient's Destination | | X |
| 318 | Destination Provider Number | | X |
| 319 | Previous Provider Number | | X |
| 324 | Blood Furnished | | X |
| 325 | Blood Replaced | | X |
| 326 | Blood Not Replaced | X | |
| 322 | Procedure Charge | X | |
| 323 | Drug Charge | X | |
| 305 | Prescribing Physician Number | X | |
| 314 | Place of Service | X | |
| 327 | Units of Service | X | |
| 330 | Medicare Cash Deductible Amount | X | |
| 331 | Medicare Blood Deductible Amount | X | |
| 332 | Medicare Coinsurance Amount | X | |
| 372 | Error Codes (occurs 10 times) | X | |
| 374 | Date Entered Suspense | X | |
| 375 | Number of Corrective Action Attempts | X | |
| 379 | Leave Days | X | |
| 378 | Date of Surgery | X | |
| 377 | Override Codes | X | |
| 386 | Prescription Number | X | |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Claims Processing Suspense File | CP-F-Ø6 |
| **SUBSYSTEM NAME** | **DATE** |
| Claims Processing | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 387 | Approval Authority | | X |
| 333 | Medicare Coinsurance Days | X | |
| 388 | Screening Results Code | X | |
| 389 | Screening Referral Code | X | |
| 390 | Screening Related Treatment | X | |
| 392 | Medicaid Deductible Amount | | X |
| 393 | Medicaid Copayment Amount | | X |
| 397 | Operating Physician Number | | X |
| 398 | Nature of Admission | | X |
| 399 | Certification Status | | X |
| 400 | Certification/Recertification Date | | X |
| 401 | Certification Review Indicator | | X |
| 402 | Days Certified Initially | | X |
| 403 | Total Days Certified | | X |
| 404 | Number of Requests for Extension | | X |
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# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Medicare Provider Cross-Reference File | RF-F-05 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |
| **SEQUENCE** | **FILE TYPE** |
| Medicare Provider Number | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

This file is updated by the Provider Edit and Update Module of the Provider Subsystem.

**PURPOSE AND FUNCTION**

This file is used to convert Medicare provider numbers to Medicaid provider numbers so that Medicare charge data can be used to update the Reasonable and Customary Charge File. This file could also be used if Medicare crossover claims were received on a computerized file from Medicare carriers or intermediaries to convert Medicare provider numbers to Medicaid provider numbers.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Medicare Provider Cross-Reference File | RF-F-05 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 214 | Medicare Provider Number | X | |
| 201 | Provider Number | X | |
| 209 | Provider Group Number | | X |

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

# FILE DEFINITION

| FILE NAME | FILE NO. |
|---|---|
| Medicare Procedure Cross-Reference File | RF-F-06 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |
| **SEQUENCE** | **FILE TYPE** |
| Medicare Procedure Code | [X] EDP [ ] MANUAL |

**UPDATE PROCEDURE**

This file is updated by the Procedure, Diagnosis and Formulary Module of the Reference File Subsystem.

**PURPOSE AND FUNCTION**

This file is used to convert Medicare procedure codes to Medicaid procedure codes so that Medicare charge data can be used to update the Reasonable and Customary Charge File.

**REMARKS**

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
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# FILE DESCRIPTION

| FILE NAME | FILE NO. |
|---|---|
| Medicare Procedure Cross-Reference File | RF-F-06 |
| **SUBSYSTEM NAME** | **DATE** |
| Reference File Subsystem | 12/Ø3/73 |

| ELEMENT NO. | DATA ELEMENTS | RECOMMENDED MINIMAL | |
|---|---|---|---|
| 532 | Medicare Procedure Code | X | |
| 500 | Procedure Code | X | |
| 533 | Procedure Cross-Reference Status | | X |

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
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# DATA ELEMENT
## INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Reference File

INPUT: Medicare Charge File (RF-I-04); Suspense File Listing Requests (RF-I-03); Procedure, Diagnosis, and Formulary File Listing Requests (RF-I-02); Procedure, Diagnosis, and Formulary File Changes (RF-I-01); Claims Processing Suspense File (CP-F-06); Medicare Procedure Cross-Ref. File (RF-F-06); Medicare Provider Cross-Ref. File (RF-F-05); Master Skeletal History File (RF-F-04); Current Skeletal History File (RF-F-03); Reasonable and Customary Charge File (RF-F-02); Procedure, Diagnosis, and Formulary File (RF-F-01)

OUTPUT: Procedure, Diagnosis, and Formulary Error List (RF-O-01); Procedure, Diagnosis, and Formulary Proof List (RF-O-02); Procedure, Diagnosis, and Formulary File Listing (RF-O-03); Regional Charge Listing by Region (RF-O-04); Reasonable Charge Listing by Provider (RF-O-05); Suspense File Listing (RF-O-06); Skeletal History File Summary (RF-O-07); Procedure, Diagnosis, and Formulary File (RF-F-01); Reasonable and Customary Charge File (RF-F-02); Current Skeletal History File (RF-F-03); Master Skeletal History File (RF-F-04); Medicare Procedure Cross-Ref. File (RF-F-06)

| ELEMENT NUMBER | DATA ELEMENT NAME |
|---|---|
| 101 | Recipient ID Number |
| 108 | Recipient County Code |
| 109 | Recipient Aid Category |
| 201 | Provider Number |
| 209 | Provider Group Number |
| 214 | Medicare Provider Number |
| 220 | Provider Specialty Code |
| 300 | Transaction Control Number |
| 301 | Category of Service |
| 302 | Transaction Code |
| 306 | Primary Diagnosis Code |
| 312 | Beginning Date of Service |
| 313 | Ending Date of Service |
| 314 | Place of Service |
| 315 | Refill Indicator |
| 316 | Patient Status |
| 322 | Procedure Charge |
| 323 | Drug Charge |
| 327 | Units of Service |
| 328 | Third Party Liability Action |
| 329 | Third Party Liability Amount |
| 349 | Payment Amount |
| 350 | Date of Adjudication |
| 351 | Adjudication Status |
| 372 | Error Codes |
| 374 | Date Entered Suspense |
| 375 | Number of Correction Attempts |
| 384 | Type of Service |
| 386 | Prescription Number |
| 500 | Procedure Code |
| 501 | Drug Code |
| 502 | Diagnosis Code |
| 503 | Maximum Days of Supply for Drug |
| 504 | Reference File Transaction Code |
| 505 | Drug Name |
| 506 | Minimum Days of Supply for Drug |
| 507 | Drug Wholesale Cost |
| 508 | Maximum Allowed Price |
| 509 | Drug Classification |
| 510 | Procedure Name |
| 511 | Diagnosis Name |
| 512 | Professional Fee Indicator |
| 513 | Unit of Measure |
| 514 | Package Quantity |
| 515 | Reference File Charge Field |
| 516 | Procedure Indicator |
| 517 | Procedure Format |
| 518 | Diagnosis Indicator |
| 519 | Diagnosis Format |
| 520 | Formulary Indicator |
| 521 | Formulary Format |
| 522 | Listing Content |
| 523 | Listing Sequence |
| 524 | Valid Sex Indicator |
| 525 | Age Range Indicator |
| 526 | Region Code |
| 527 | CRVS Conversion Factor |
| 528 | Drug Cancellation Date |
| 529 | Medicaid Reasonable Charge |
| 530 | Sub-File Indicator |
| 531 | Medicare Reasonable Charge |
| 532 | Medicare Procedure Code |
| 533 | Procedure Cross-Reference Status |

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